Ontario Health

Surgical Information Program

Surgery Data Standardization Guide

December 2020

Version 2.0

Table of Contents

Acronyms 3
Tables 5
Introduction 6
Surgical Information Program 7
Wait Time Information System (WTIS) 8
Scope of Data Entered in the WTIS 10
Priority Levels and Access Targets 20
Priority Levels and Elective Procedures 22
Combination Procedures 24
Staged Procedures 25
Patient Delays (DARCs and DARTs) 26
System Delays 32
Decision to Treat (DTT) 36
Editing or Updating Waitlist Entries 39
Referral Source 41
Referral Type 43
Responsibility for Payment 46
Appendix A: Wait 1 and Wait 2 Case Studies 47
Appendix B: Data Elements and System Labels 76
Appendix C: History of Ontario's Wait Time Strategy (WTS) 86
Appendix D: Funding and Wait Time Reporting 92

Acronyms

Acronym	Definition
ALC	Alternate Level of Care
ATC	Access to Care
CIAC	MSK Assessment Centre
CIHI	Canadian Institute for Health Information
DAD	Discharge Abstract Database
DAP	Diagnostic Assessment Program
DARC	Dates Affecting Readiness to Consult
DART	Dates Affecting Readiness to Treat
DBCR	Delayed Breast Cancer Reconstruction
DQ	Data Quality
DI	Diagnostic Imaging
DTT	Decision to Treat
ER	Emergency Room
FOBT	Fecal Occult Blood Test
GUI	Graphical User Interface
HCP	Health Care Provider
HCN	Health Card Number
HL7	Health Language 7
LHIN	Local Health Integration Network
MFM	Message Failure Management
MIS	Standards for Management Information Systems in Canadian Health Organizations
MLAA	Ministry LHIN Accountability Agreement
NACRS	National Ambulatory Care Reporting System
OBSP	Ontario Breast Screening Program
OH	Ontario Health

Acronym	Definition
OR	Operating Room
PAC	Pre-Admit Clinic Appointment
PARR	Post Anaesthetic Recovery Room
PAT	Priority Assessment Tool, part of the Quick Reference Card
PCR	Provincial Client Registry
QBP	Quality Based Procedure
QRC	Quick Reference Card, includes the Priority Assessment Tool
SD	Service Detail
SETP	Surgical Efficiency Targets Program
SIP	Surgical Information Program
TCR	Target Change Request Form
VAC	Veterans Affairs Canada
WLE	Waitlist Entry
WTIS	Wait Time Information System
WTS	Wait Time Strategy

Tables

Table #	Table Title	Page
Table 1	Integration Levels for Surgery Data	9
Table 2	WTIS Reports with Case Level Information	9
Table 3	Wait 1 and Wait 2 Methodology	10
Table 4	Endoscopy Reporting in the WTIS	12
Table 5	Procedures Not Reported in the WTIS	13
Table 6	Surgical Oncology Service Detail 2	15
Table 7	Oncology Diagnostic and Treatment Surgery with Different Surgeons	18
Table 8	Oncology Diagnostic and Treatment Surgery with Same Surgeon	18
Table 9	Surgical Oncology SD2 Priority Levels and Access Targets	21
Table 10	DART and DARC Definitions and Examples	25
Table 11	System Delay Definitions and Examples	30
Table 12	Decision to Treat (DTT) Scenarios	34
Table 13	Demographic Data Elements	74
Table 14	Wait 1 Data Elements and System Labels	75
Table 15	Wait 2 Data Elements and System Labels	79
Table 16	WTIS Evolution	84
Table 17	WTIS Surgical Service Areas	86

Introduction

About this Guide

This guide provides information and guidance on how to report surgical patients' wait times for consultation and surgery in the Wait Time Information System (WTIS).

This guidance has been consolidated from historical materials in an effort to make it easier for people using the WTIS to reference. Separate from this guide, information on surgical efficiency reporting is available in the SETP Data Standardization Guide.

This document provides details on WTIS reporting requirements for topics and scenarios that have been past areas of focus for refinement and education (Table of Contents).

A collection of WTIS case studies is included in Appendix A. A complete list of surgery wait time data elements and definitions is included in Appendix B.

An outline of the Ontario Wait Time Strategy, the Patients First: Action Plan and a brief history of the evolution of the WTIS is also provided for context in Appendix C. Information on the relationship between wait time reporting and funding is included in Appendix D.

If you have any questions or comments about materials in this document, please contact atc@ontariohealth.ca.

Surgical Information Program

The Surgical Information Program (SIP) is a line of business at Ontario Health and operates with the following goals:

- Work towards ensuring access to care for all surgical patients
- Enable performance management and accountability
- Improve healthcare results and quality of care through provision of high quality data
- Assist hospitals, LHINs and the Ministry of Health (ministry) to use data in a meaningful way to drive positive and proactive system changes such as:
    - Inform benchmarking
    - Identify access issues and opportunities to reduce wait times
    - Increase understanding of patient care challenges
    - Support performance management accountabilities, performance improvement strategies and improvement in quality of care for surgical patients

Wait Time Information System (WTIS)

Since 2006, the Wait Time Information System (WTIS) has been leveraged as the technology system for Ontario to collect accurate and timely surgery, DI and ALC wait time data as a key component of Ontario's Wait Time Strategy. The WTIS is a web-based application that collects surgery, diagnostic imaging (CT/MRI), Alternate Level of Care (ALC), and wait time data to inform our understanding of the patient journey. The WTIS provides clinicians and other healthcare professionals with the tools they need to effectively assess patient waits in a standardized manner. The WTIS is built on the foundation that timely, good quality information drives health system changes and improvements.

Purpose of WTIS Data Capture

The WTIS is used to collect wait times information from wait time funded hospitals across Ontario. The information collected is used to report on patient access to services. The WTIS supports the management of surgical waitlists by tracking patients waiting for a specific procedure based on their defined priority level. As much as possible, wait time reporting guidance is framed to best reflect the wait time from a patient's perspective.

Information collected in the WTIS is designed to be used by clinicians and administrators to inform decision-making and planning to improve access to care. At the same time, it informs performance management and improvement in hospitals across the province.

Data Entry

Surgical wait time data is primarily entered into the WTIS by a surgeon's staff using an online web browser. Data is entered manually or electronically using HL7 interface messaging, or a combination of these two methods. Some facilities coordinate waitlist entry submission through OR booking resources. Waitlist entries for patients are opened within 48 hours of the Decision to Treat (DTT), and closed within 48 hours of the date the procedure takes place.

The WTIS application and platform ensure the consistent and timely capture, tracking, and reporting of the waitlist entry information through a combination of online screens, and integration with the Provincial Client Registry (PCR) and hospital information system interfaces. The WTIS provides the designated users with a variety of data error management, auditing, and reporting functions to facilitate the tasks of ensuring timely and accurate data reconciliation and reporting.

There are three integration levels facilities use to submit the required Surgery data to the WTIS.

Integration Level	Description of Integration Level
Basic	Waitlist entries are created and modified via manual data entry through a web-based GUI. There are no HL7 messages.
Standard	Waitlist entries are created and modified via manual data entry through a web-based GUI and are closed electronically via HL7 interface messaging.
Complex	All waitlist entry data is submitted electronically via HL7 interface messaging.

Table 1: Integration Levels for Surgery Data

WTIS Reports

The WTIS provides users with case level information as seen in Table 2.

Report	Description	Audience
Waitlist Entries Extract Report	Provides information on all open or closed surgery waitlist entries for a specified month	WTIS Surgery Coordinators and surgeons' offices
Potential Duplicate Waitlist Entries Report	Identifies waitlist entries that may be duplicates in the WTIS	WTIS Surgery Coordinators and surgeons' offices
Patients on Surgical Waitlist by Priority	Displays the number of patients on the waitlist by their respective priority level	WTIS Surgery Coordinators and surgeons' offices
Patients on Surgical Waitlist by Surgeon	Displays the number of patients on the waitlist by surgeon	WTIS Surgery Coordinators and surgeons' offices
MFM Report	Helps users identify waitlist entries with errors	WTIS Surgery Coordinators and surgeons' offices

Table 2: WTIS Reports with Case Level Information

Data from the WTIS feeds into ATC reporting products that are updated on a regular basis, including:

- Online business intelligence tool (iPort™ Access) for LHINs, facilities and surgeons
- Microsoft Excel dynamic reports for LHINs, ministry, facilities, surgeons and ATC Clinical Leads

A detailed catalogue of reporting products is available on the ATC Information Site.

Scope of Data Entered in the WTIS

Wait 1 and Wait 2

The WTIS captures two parts of the patient's wait time for surgery: Wait 1 and Wait 2 as seen in Table 3.

Metric	Methodology
Wait 1	**Measured from the date the clinician's office receives the referral (Referral Date) to the first time the patient meets the clinician (Consult Date).** • Captured for patients who make a DTT with their clinician • Captured for the first consult; it is possible a patient could have multiple consults before making a DTT, but only the first consult is captured • Reported retrospectively, once the patient and clinician make a DTT • Referral may be received via fax, email, phone call • The Consult Date **is not included** in the calculation • The Referral Date is included in the calculation • DARCs are subtracted from the patient's Wait 1 wait time • Both start and end dates of DARCs are included in the calculation • System Delays are not subtracted from the patient's Wait 1 wait time • For Central Intakes or Diagnostic Assessment Programs (DAPs), Wait 1 begins when the centre receives the referral, instead of the clinician's office
Wait 2	**Measured from date the patient and clinician agree to surgery (DTT Date) and ends on the actual Procedure Date.** • Captured for all surgical procedures that take place in a fully-equipped OR, with some exceptions noted in the Scope of the WTIS-Procedures Not Reported section • Procedure date **is not included** in the calculation • DTT date is included in the calculation • DARTs are subtracted from patient's Wait 2 wait time • Both start and end dates of DARTs are included in the calculation • System Delays are not subtracted from the patient's Wait 2 wait time

Table 3: Wait 1 and Wait 2 Methodology

Fully-Equipped ORs

The WTIS captures wait times for all surgical procedures performed in a fully-equipped OR. The one exception is cataract procedures. These are entered into the WTIS regardless of the location of where they are performed.

WTIS OR locations (MIS Functional Centres) include the following:

- 71260 - In-patient OR
- 71262 - In-patient OR / PARR - used by small hospitals
- 71367 - Day surgery pre and post-operative care
- 71360 - Day surgery OR
- 71362 - Day surgery combined OR and PARR
- 71365 - Day surgery post-anesthetic recovery room
- 71369 - Day surgery combined OR, PARR and pre and post care

Note: The presence or absence of surgical equipment does not define a fully-equipped OR. Surgical equipment can be permanent, temporary or mobile within these functional centres.

Paediatric Surgery

All surgical procedures performed on paediatric patients should be captured under the appropriate paediatric service area. In the WTIS, a paediatric patient is:

- Any patient less than 18 years old at the time of the DTT (in Ontario, 18 is legally the age an individual becomes an adult); **or**
- Any patient less than 23 years old at the time of the procedure, at the discretion of the treating clinician, who is undergoing a procedure related to an underlying congenital, developmental or genetic disorder such as a craniofacial abnormality, muscular dystrophy, spina bifida, or cerebral palsy

Note: This definition also applies to persons with disabilities.

Cosmetic Surgery

All cosmetic or aesthetic surgery performed in a fully-equipped OR in a wait time-funded hospital must be captured in the WTIS. For example, a plastic surgeon would report cosmetic surgery using the Aesthetic Surgery Service Detail (SD) 1 under the Plastic & Reconstructive Surgery Service Area.

Endoscopy Procedures

Specific types of endoscopy (scope) procedures are reported in the WTIS while others are excluded. There are four categories of scopes reported in the WTIS:

- Scopes performed for suspected or known cancer in a fully-equipped OR
- Scopes performed for cancer surveillance in a fully-equipped OR
- Scopes performed as a less invasive approach for surgical treatment in a fully-equipped OR
- Scopes performed for non-cancer paediatric orthopaedic or paediatric gynaecology patients

Table 4 provides a detailed summary of endoscopy reporting in the WTIS.

Type of Scope	Reportable in the WTIS?
Diagnostic scope performed in a fully-equipped OR for known or suspected cancer	Reported using the Surgical Oncology Service Area or appropriate Paediatric Service Area.
Diagnostic scope performed in a fully-equipped OR for cancer surveillance	Reported using the Surgical Oncology Service Area or appropriate Paediatric Service Area.
Diagnostic scopes for non-cancer adult patients	**Not** reported in the WTIS.
Diagnostic scopes performed in a fully-equipped OR for non-cancer paediatric patients	Reported using the following reporting categories: • Paediatric Gynaecologic Surgery - SD1: Diagnostic Procedures • Paediatric Gynaecologic Surgery - SD1: Solid Tumour • Paediatric Orthopaedic Surgery - SD2: Diagnostic Knee Arthroscopy
Scopes performed in a fully-equipped OR as a less invasive approach for surgical treatment for cancer or non-cancer conditions	Reported using the appropriate benign or surgical oncology service area.
Diagnostic scopes for cancer prevention, such as polypectomy	**Not** reported in the WTIS.
Scopes performed for cancer screening	**Not** reported in the WTIS.

Table 4: Endoscopy Reporting in the WTIS

For more information on cancer diagnostic scopes, see the Surgical Oncology section.

Procedures Not Reported in the WTIS

Some procedures are not reported in the WTIS, usually because they are managed/reported by other organizations, generally do not occur in a fully-equipped OR, or are not a focus of the WTIS. See Table 5 for more details.

Procedure Not Reported in WTIS	Description/Examples	Rationale
Capsulotomies performed as primary procedure	Sometimes performed to treat complications following cataract surgery.	This is a laser treatment procedure usually not performed in an operating room.
Cardiac surgery procedures, pacemakers and procedures for bypass surgery performed on adult patients	Angiograph Angioplasty Bypass Surgery	Captured by CorHealth using a modified module of the WTIS.
Emergency bone fractures procedures	Primary surgery to repair bone fracture within 7 days of ER DTT.	Emergency procedures are not reported for Orthopaedic Surgery.
Flow Studies, Urodynamics, & Bladder Instillations	Evaluates how well the lower urinary tract is working. It also helps determine if there is a blockage of normal urine outflow.	Non-cancer diagnostic procedures are out of scope for the WTIS.
Injections for adults	Cortisone	Not a surgical procedure.
Non-cancer diagnostic surgical procedures for adult patients	Exploratory laparotomy to investigate gallstones and state of gallbladder. Exploratory laparotomy to assess a liver abscess. Exploratory adult arthroscopy to attempt to diagnosis knee pain.	Non-cancer diagnostic procedures are out of scope for the WTIS.
Obstetric procedures, in-utero procedures, and procedures secondary to obstetric procedures	Abortion D&C Following Abortion Fetal Interventions	Most of these procedures are no longer performed in ORs, but rather in clinic settings, which are out of scope for the WTIS.

Procedure Not Reported in WTIS	Description/Examples	Rationale
Pain management procedures performed by anaesthetists	Facet-joint injections for back pain Epidural steroid injection	Not a surgical procedures.
Pharmacotherapy, chemotherapy and instillation treatment	Delivery of drugs or chemicals to the disease site to reduce or eliminate cancer.	Do not meet the definition of a cancer surgery procedure.
Procedures performed by radiation oncologists	Radiation delivered to a tumour to reduce or eliminate the tumour.	Typically does not take place in an OR.
Transplant surgeries for organs other than corneas	Kidney transplant Lung transplant	Data captured through the Canadian Organ Replacement Registry.
Unplanned procedures	The removal of a polyp as a result of an otolaryngic scope.	There is no wait time for an unplanned procedure.

Table 5: Procedures Not Reported in the WTIS

Surgical Oncology

All adult surgical procedures for known or suspected cancer performed in a fully-equipped OR should be reported to the WTIS as a surgical oncology procedure, regardless of the surgical specialty of the performing clinician. Information about paediatric surgical oncology is available here.

Suspicion of Cancer

The suspicion of cancer is determined by the clinician based on available information and may be with or without pathology results. If the clinician still suspects cancer with a negative biopsy, the procedure is considered to be for suspected cancer and is reported to the WTIS under Surgical Oncology.

If the clinician rules out cancer through the biopsy and then performs surgery to excise a benign tumour, then the surgery procedure is for a benign indication and is reported under the appropriate benign surgical service area.

Surgical Oncology Definitions

Adult surgical oncology procedures are reported using the surgical oncology SD1 that best describes the location of the tumour. Furthermore, the surgical procedure is reported using one of four SD2s that best describe the purpose of the surgical procedure: Treatment, Reconstruction, Diagnostic or Palliative.

SD2: Treatment	
Definition	**Examples**
The definitive therapeutic surgical treatment of a biopsy-proven cancer or highly suspected cancer.	Excision of a tumour where the patient has a positive pathology prior to surgery.
Diagnostic surgical procedures where the operation would be both a definitive treatment and diagnostic for that condition. This would apply to procedures for malignant and premalignant conditions, and carcinoma-in-situ.	Parotidectomy Thyroidectomy Oopherectomy
Surgical procedures required to treat primary complications of cancer surgery.	Tracheotomy, ileostomy/colostomy for bowel obstruction secondary to cancer. Spinal decompression for cancer, surgical procedures to control bleeding from cancer.

The one exception is thyroidectomies where there is a very low probability of cancer; these procedures should not be captured under the Surgical Oncology Service Area.

- If the thyroidectomy is performed by a General Surgeon, it should be captured under the General Surgery Service Area under the Thyroid SD2 category.
- If the thyroidectomy is performed by an Otolaryngologist Surgeon, it should be captured under the Otolaryngic Surgery Service Area under the Thyroid Surgery SD2 category.

SD2: Reconstruction	
Definition	**Examples**
Reconstruction and rehabilitation in specific situations where the surgical procedure is a requirement to rehabilitate the patient after cancer treatment. Surgery to treat complications arising from surgical oncology reconstructive surgery.	Repair of the abdominal wall following treatment of stomach cancer.

The one exception is Delayed Breast Cancer Reconstruction (DBCR) and complications arising from this surgery. DBCR refers to any breast reconstruction not performed during the primary intervention for breast cancer. These procedures are reported under the Plastic & Reconstructive Surgery Service Area as DBCR or under the General Surgery Service Area as Benign Breast Disease depending on the specialty of the clinician. Surgery to adjust the size of the other breast unaffected by disease should also be reported under these categories.

SD2: Palliative	
Definition	**Examples**
Surgical procedure is not intended to be curative but is intended to enhance quality of life through pain and symptom prevention. Surgical procedure is intended to provide pain and symptom control for a patient who is living with or dying from cancer.	Central Line insertion performed in a fully-equipped OR to facilitate palliation of cancer. Ommaya reservoir placed into the brain for chemical palliative infusion. Palliative pleuroscopy and a talc poudrage performed by Thoracic Surgeon. Patient has metastatic breast cancer with metastasis to the bladder which is causing retroperitoneal obstruction from the tumour. This requires the insertion of ureteral stents to bypass obstruction. Patient had a colonic stenting for a near obstructing rectal tumour.
SD2: Diagnostic	
Definition	**Examples**
Non-therapeutic surgical diagnosis of a suspected cancer. The surgical procedure is required for staging of cancer (e.g. panendoscopy, mediastinoscopy) and diagnosis of cancer where a surgical approach is required to rule out a malignancy (e.g., endocrine tumours).	Partial excision of a disease site to facilitate biopsy Cancer surveillance procedures

Table 6: Surgical Oncology Service Detail 2

Diagnosis Followed by Treatment

Diagnostic procedures will often be followed by treatment procedures. If the diagnostic procedure and surgical procedure are performed by different clinicians, then it is possible both waitlist entries will have their own Wait 1 data if the patient had a referral to each clinician, as per Table 7.

WLE #1
Surgical Oncology – Diagnostic
Dr. Smith
Referral Type: New Referral | Referral Source: Other | Referral Date: 1 May 2016 | Consult Date: 1 June 2016
DTT: 1 June 2016 | Procedure Date: 1 June 2016
WLE #2
Surgical Oncology – Treatment
Dr. Brown
Referral Type: ReReferral | Referral Source: Other | Referral Date: 2 June 2016 | Consult Date: 10 June 2016
DTT: 10 June 2016 | Procedure Date: 30 June 2016

Table 7: Oncology Diagnostic and Treatment Surgery with Different Surgeons

In some instances, a patient will be referred to a clinician who will perform both the diagnostic and treatment cancer surgery procedures. Usually a patient with multiple procedures and one surgeon would have their Wait 1 information included in the first waitlist entry (in this case the diagnostic oncology procedure). However, the guidance for this scenario is to report the patient's Wait 1 information within the second waitlist entry (surgical oncology-treatment).

The reason for this is diagnostic waitlist entries are excluded from performance reporting. To ensure the patient's Wait 1 information can be included in performance reporting, it is therefore reported in the surgical oncology-treatment waitlist entry. The data should be submitted as per Table 8.

WLE #1
Surgical Oncology – Diagnostic
Dr. Smith
Referral Type: No Referral/Follow-Up- Existing Patient (New Condition)
DTT: 1 June 2016 | Procedure Date: 1 June 2016
WLE #2
Surgical Oncology – Treatment
Dr. Smith
Referral Type: New Referral | Referral Source: Other | Referral Date: 1 May 2016 | Consult Date: 1 June 2016
DTT: 2 June 2016 | Procedure Date: 30 June 2016

Table 8: Oncology Diagnostic and Treatment Surgery with Same Surgeon

Oncology Screening, Prevention and Prophylactic Surgery

Screening, prevention, and prophylactic cancer procedures (where there is an increased statistical risk of cancer but no suspicion of a physical tumour/mass at the DTT Date) should be captured under the appropriate benign surgical Service Area with the exception of endoscopies performed for this purpose which are not reported in the WTIS. For example, a colonoscopy for a positive FOBT is considered screening and is not reported in the WTIS.

If a cancer screening procedure results in a need for cancer treatment surgery, then the cancer treatment surgery is reported in the Surgical Oncology Service Area. However, the patient would have no Wait 1 for surgery because the patient was referred for screening and no subsequent referral was required for a surgical consultation. The Referral Type for the treatment surgery would be No Referral/Follow Up - Existing Patient (New Condition). See Appendix A for a detailed example.

Metastatic Oncology Surgery

Surgeries for metastatic cancers are reported using the SD which best describes the location/site of the current tumour. For example, if bladder cancer has metastasized to the lung, the waitlist entry for an adult lung cancer procedure should be entered under the Surgical Oncology Service Area, SD1 - Lung.

Preparation Procedures and Post-Cancer Procedures

Surgical procedures performed to prepare a patient for cancer surgery or those performed post-cancer to reverse such procedures are reported under the appropriate benign surgical service area. For example, a preparation procedure takes place in a fully-equipped OR to insert a feeding tube and bypass the esophagus prior to cancer surgery, or a colostomy reversal takes place after cancer surgery.

Paediatric Surgical Oncology

There is no separate surgical oncology service area for paediatric patients. The excision of a suspected or known malignant tumour should be reported under the appropriate Paediatric Service Area for paediatric patients, using the Solid Tumour category.

Diagnostic scopes performed for known or suspected cancer on paediatric patients in a fully-equipped OR are also reported using the Solid Tumour category. If the scope is for gynaecology-related cancer, the Paediatric Gynaecologic Surgery, SD1: Diagnostic Procedures category can be used to report these procedures.

Priority Levels and Access Targets

The priority levels, description, and prioritization guidance were created by an expert panel of clinicians to help guide the professional decision-making of clinicians in Ontario by utilizing standardized Priority Access Tool (PAT).

Note: The PAT is a guide to assist clinicians in prioritization of patients, and clinicians should use their judgment to assign priorities based on the symptoms, condition and presentation of the patient. To assist surgeons in the prioritization of patients, broad patient descriptions are provided in the PAT for each service area.

PATs for all surgical service areas on are available on the ATC Information Site in the Quick Reference Card (QRC) for each surgical services area.

Surgical priority levels and associated access targets for procedures reported in the WTIS are distinct from the Surgical Priority Classification Codes for the SETP.

Surgical Oncology Priority Levels

Treatment surgical oncology cases are assigned a priority level using the Surgical Oncology PAT. This PAT provides guidance that all patients with known or suspected invasive cancer, that are not highly aggressive or emergent, should be assigned a Priority Level 3 (semi-urgent). Patients diagnosed with indolent malignancies should be assigned a Priority Level 4 (elective (less urgent for cancer)).

When a patient is referred by their family physician for a surgical consultation for a benign condition and at the time of the consultation the patient's surgery is booked for an oncology treatment, a waitlist entry should be opened with a Wait 1 priority level that will be based on the surgical oncology PAT.

For diagnostic surgical procedures where there is a reasonable expectation of cancer, there is insufficient information to appropriately prioritize patients. For this reason, all diagnostic surgical procedures performed in a fully-equipped OR for suspected cancer will be automatically assigned a 14-day access target in the WTIS. The rationale for developing a non-priority based diagnostic wait time target is that during the diagnostic phase, it is not possible to prioritize a patient to a priority level. A diagnosis of cancer or suspicion of cancer is not possible without completion of the diagnostic phase. Pathology, imaging and other tests are required to define the priority level; therefore, the priority level assignment occurs during Wait 2.

Note: Palliative and reconstructive cases do not require a priority level and are not assigned an access target.

Surgical Oncology SD 2	Priority Level Assigned	Access Target Assigned
Treatment	Yes	Yes
Reconstructive	No	No
Diagnostic	No	Yes
Palliative	No	No

Table 9: Surgical Oncology SD2 Priority Levels and Access Targets

Change in Priority Level

If a patient experiences a change in medical status, either improved or deteriorated status, it would be up to the clinician's discretion to change the priority level and the waitlist entry should be updated accordingly. See the Editing or Updating Waitlist Entries for more information on editing priority levels.

Priority Levels and Elective Procedures

P2, P3 and P4 cases are considered elective cases in the WTIS. While non-elective cases are excluded from Quality Based Procedures (QBP), the QBP definition does not contain any reference to Wait Time Priority Levels. The following scenario illustrates how a priority level can change when a patient's condition deteriorates and surgery becomes more urgent.

The table below illustrates possible variations of scenarios and reporting in the WTIS in which a patient's condition becomes more urgent and their priority level changes while waiting for surgery. Please note this is not an exhaustive list and there may be other reasons not captured in the table below.

Clinical Scenario & Initial Reporting in WTIS	Reporting Options in the WTIS Based on Scenario
Patient had a surgical consultation with their surgeon and is scheduled for surgery. Wait 1 (referral received to first surgical consultation) is entered into the WTIS. Unexpectedly, while waiting for surgery the patient deteriorates and **becomes a P1 case.**[1]	**Option 1:** Waitlist entry is updated to reflect the change in priority level to P1 but the DTT date remains the same because the surgery is performed by the *original consulting* surgeon. The waitlist entry is closed once surgery is complete. **This is not considered an elective case.** **Option 2:** If the surgeon who performed the urgent surgery **is not** the original consulting surgeon, the waitlist entry is updated by the original surgeon and the patient is removed from the WTIS by selecting "Procedure No Longer Required." • **Note: If it is a P1 oncology treatment case**, the *new/different* surgeon opens a new waitlist entry in the WTIS, indicating the new priority level, and use their assessment date as the DTT date. The entry is closed once surgery is complete. **This is not considered an elective case.** **Option 3:** The patient's surgery was completed by a *new/different* surgeon; however, the patient is not removed from the *original consulting* surgeon's open waitlist and the case remains open indefinitely in the WTIS. Surgeon's offices should have process in place to regularly review open waitlist entries to ensure the accuracy of open cases.
Patient had a surgical consultation with their surgeon and is scheduled for surgery. Wait 1 (referral received to first surgical consultation) is entered into the WTIS.	**Option 1**: Waitlist entry is updated to reflect the change in priority level to P1 but the DTT date remains the same because the surgery is performed by the *original consulting* surgeon. The waitlist entry is closed once surgery is complete. **This is considered an elective case.** **Option 2:** If the surgeon who performed the urgent surgery **is not** the original consulting surgeon, the waitlist entry is updated by the original surgeon and the patient is removed by selecting "Procedure No Longer Required." Since the patient's priority level changed, the *new/different* surgeon opens a new waitlist entry in the WTIS indicating the new priority

Clinical Scenario & Initial Reporting in WTIS	Reporting Options in the WTIS Based on Scenario
Unexpectedly, while waiting for surgery the patient deteriorates and becomes a **P2 or P3 case**[1].	level and uses their assessment date as the DTT date. The entry is closed once the surgery is complete. **This is considered an elective case.** **Option 3:** The patient's surgery was completed by a *new/different surgeon*; however, the patient is not removed from the *original consulting* surgeon's open waitlist and the case remains open indefinitely in the WTIS. Surgeon's offices should have process in place to regularly review open waitlist entries to ensure the accuracy of open cases.
Patient was NOT seen for surgical consultation prior to deterioration (and subsequent surgery). Since there was no surgical consultation there is NO Wait 1. A waitlist entry is not created in the WTIS.	The patient deteriorates and requires urgent surgery. This patient is out of scope of the WTIS. **This is not considered an elective case.**

[1]The surgeon determines the patient's priority level. If a patient experiences a change in medical status, it would be up to the clinical judgment of the surgeon to reassess and change the patient's priority level accordingly.

Combination Procedures

Clinically Related

Combination procedures are two or more procedures performed during the same surgical episode for the purposes of treating clinically related conditions. Two surgical procedures are clinically related if they have a treatment, pathological or anatomical relationship wherein the optimal operative intervention requires the two procedures to take place at the same time.

- For example, a Neurosurgeon is removing a brain tumour from a patient and subsequently a plastic surgeon will revise the skin flap over the tumour site
- Combination procedures also may include bilateral procedures where a patient has concurrent procedures for both hips, both knees, both wrists, etc.

When such a scenario occurs, only one waitlist entry should be reported in order to reflect the primary procedure. The reason: only the primary procedure is reported is that the purpose of the WTIS for surgical cases is to measure access to the OR and availability of OR resources. The surgeon who performs the primary procedure will report it in the WTIS.

Whenever there is a suspected cancer diagnosis, the oncology procedure will always be captured as the primary procedure in the WTIS; otherwise, the lead surgeon for the combination procedure will determine which procedure is primary.

Combination Procedure Reporting Categories

Currently, there are three Service Areas with combination procedure SDs under which specific combination procedures can be captured in the WTIS. All other combination procedures are reported using the reporting category that best describes the primary procedure determined by the lead surgeon.

Ophthalmology

- If a cataract procedure and other ophthalmic procedure are performed during the same surgical episode, one waitlist entry is opened using SD 1- Combination Cataract and Other Procedure, and SD 2 as applicable (Corneal Transplant, Glaucoma, Vitrectomy, or Other Ophthalmic Procedure)
- Bilateral ophthalmic procedures performed during the same surgical episode are reported in one waitlist entry under the appropriate SD 1 and SD 2- Bilateral

General Surgery

- The most commonly performed combination procedures in General Surgery include procedures performed on the small and large bowel. In the WTIS, there are SD 1 categories to capture combination procedures performed in the digestive system (e.g. Digestive System Surgery - Ileocolic).

Gynaecology Surgery

- If a gynaecology patient undergoes surgery to repair prolapse and treat urinary incontinence during the same operative episode, the combination procedure should be reported under SD 1- Combination Prolapse and Urinary Incontinence Surgery.

Clinically Unrelated

When two clinically unrelated surgical procedures are performed, as either an administrative convenience and/or to avoid multiple anaesthetics and/or operative episodes for the patient, this is not considered a combination procedure and the two procedures would each have a separate waitlist entry.

- For example, a patient is booked for inguinal hernia repair and tubal ligation (two clinically unrelated procedures), on the same day to meet the best interests of the patient.

Staged Procedures

Staged procedures are multiple surgical procedures for the same patient that occur at different points in time and are clinically related.

For example, a patient has the first cataract removed in March with the second cataract removal taking place in April. To capture staged procedures in the WTIS, a waitlist for the first procedure should be opened when the clinician makes a DTT and the patient agrees to have the surgery. Once the first procedure is complete and the patient has convalesced, the clinician can reassess the patient and make the second DTT. At this time, the second waitlist should be opened for the second procedure.

The one exception to this rule is for staged bilateral cataract procedures. For staged bilateral cataract procedures, the patient usually consents to both of the recommended procedures during the first consultation. In this instance, the clinician's office opens a waitlist entry for each of the staged procedures with the same DTT date, using SD 2- Left Eye and SD 2- Right Eye for the respective waitlist entries. DART of Other Surgical Procedure is used for the second procedure to account for the time the patient is waiting for the first procedure and convalescing, starting on the DTT date and ending the day prior to surgery for the second eye.

Patient Delays (DARCs and DARTs)

The intent of the WTIS is to capture the wait time to access services from a patient's perspective. To support this measurement, the WTIS captures data elements called DARCs (Dates Affecting Reading to Consult) and DARTs (Dates Affecting Readiness to Treat) to report periods of unavailability due to patient reasons. A single waitlist entry can have a combination of multiple DARCs and DARTs depending on the scenario. This functionality is intended to improve the accuracy of data capture and reflect the patient's actual wait time for services. The case studies in this document illustrate the use of DARCs and DARTs.

Definitions

DARC: Periods of time between the referral and consult date when the patient is unavailable for a first consultation due to patient-related reasons.

The time will be subtracted from the overall Wait 1 and requires a 'to' and 'from' date in the WTIS as well as a delay reason (Table 10). The patient-related reasons do not include system-related delays such as surgeon unavailability, emergency closures or reduced clinic hours.

See Table 11 (System Delays) for more information on non-patient-related delays for consults.

DART: Periods of time between the DTT and the Procedure Date when the patient is unavailable for a procedure due to patient-related reasons.

This time will be subtracted from the overall Wait 2 and requires a 'to' and 'from' date in the WTIS as well as a delay reason. The patient-related reasons do not include system-related delays such as clinician or technician unavailability, OR closures, or scanner downtime. See Table 11 (System Delays) for more information on non-patient-related delays for surgery.

The count of patient unavailable days starts with the first day the patient indicates they are not available and ends the day the patient becomes available. The one exception is hip and knee surgery patients, where the DART may end on the date of their PAC (Pre-Admit Clinic Appointment) because the PAC visit indicates the patient is willing to undergo surgery.

DARTs and DARCs can be edited in accordance with regular waitlist entry editing rules. If the initial waitlist entry indicated none were applicable, the entry can be edited at a later date to indicate updates.

Developmentally Appropriate Wait		
Definition	**Examples**	**Instructions**
Applicable to paediatric patients only The clinician determines a consultation/surgery is required, but that it cannot occur until the paediatric patient has reached a certain stage in development.	Clinician has made the decision to proceed with strabismus repair, but the surgery cannot occur until the patient's vision is equal in both eyes.	**DART start date:** the DTT Date. **DART end date:** the date the patient reaches required developmental stage.
Inability to Contact Patient		
Definition	**Examples**	**Instructions**
The clinician's office has made a reasonable effort to contact the patient in order to schedule or confirm the date and time for the first consultation/surgery but has not been able to do so.	Clinician's office tried contacting the patient to schedule a consultation and reached them several days later. Reasonable effort is determined by the facility.	**DARC/DART start date:** the date when the facility first tried to contact the patient **DARC/DART end date:** the date when the patient was contacted.
Patient Chooses to Defer		
Definition	**Examples**	**Instructions**
The patient is unavailable for the consultation/procedure due to personal reasons (such as a vacation or a death in the family), personal preferences for the date and time of the procedure, or weather reasons (such as road and airport closures).	Patient requests to have hip or knee replacement surgery at a specific time in the future so they can go on vacation, despite being offered an earlier date.	**DART start date:** the first available surgery date offered to the patient and subsequently refused. **DART end date:** the date the patient becomes available for surgery. Where the first available surgery date is offered and it coincidentally fits with a patient's travel schedule, the patient does not need to defer the procedure and a DART is not applied.
	Patient only available during the Christmas season when their spouse will be home and able to help them.	**DART start date:** the first available surgery date offered to the patient and subsequently refused. **DART end date:** the date the patient becomes available for surgery.

	Patient and surgeon agree to proceed with surgery but patient defers the surgery in order to seek a second opinion.	**DART start date**: the date the patient tells the surgeon they will seek a second opinion. **DART end date**: the date the patient tells the surgeon they accept the opinion.
	The patient arrives on the day of the clinic visit but leaves before seeing the surgeon.	**DARC start date:** the consultation date. **DART end date:** the date the patient becomes available for a consultation once again.
	Patient's mom stated that she does not want surgery booked while the patient is still in school.	**DART start date**: the DTT date. **DART end date**: the date the patient becomes available.
	Patient scheduled for two procedures and requests that both procedures take place on the same date as a personal choice.	**DART start date**: the first available surgery date offered to the patient for the first procedure and subsequently refused. **DART end date:** the new surgery date for both procedures at once.
	Patient cancels their procedure in advance because they are not available that day.	**DART start date**: the date the patient becomes unavailable. **DART end date**: the date the patient becomes available.

Change in Medical Status		
Definition	**Examples**	**Instructions**
The patient's medical status has changed such that the first consultation/surgery cannot be performed until the patient's condition stabilizes.	Intervening or unexpected medical condition of an unknown duration prevents the patient from having a consultation/receiving treatment.	**DART/DARC start date**: the date the patient's intervening or unexpected condition started. **DART/DARC end date**: the date the patient becomes medically fit for consultation/surgery.
	Surgical procedure has to be rescheduled as a result of the patient eating prior to their surgery.	**DART start date**: the original scheduled date of surgery. **DART end date**: the date the patient is no longer at higher risk of aspiration under anaesthesia, most likely the date of surgery. If the patient cannot be re-scheduled for the procedure on the following day due to OR capacity, then a System Delay of Lack of Hospital Resources can also be applied to the waitlist entry to provide further context around the extended wait time.
	Surgery delayed because the patient was at risk for complications if they proceed with surgery due to the potential exposure to an outbreak.	**DART start date**: the date the outbreak started. **DART end date**: the date the patient is medically-cleared of symptoms.
	Patient is referred to a central intake where they undergo conservative management prior to having a consultation with their surgeon.	**DARC start date**: the date the patient begins conservative management. **DARC end date**: the date the conservative management ends.
	Last minute surgery cancellation due to patient factors.	**DART start date**: the date the surgery was cancelled. **DART end date:** the date the patient factor is no longer delaying surgery.

	Patient becomes unavailable to receive cataract surgery due to a hemorrhage in one eye	**DART start date**: the date the patient had a hemorrhage. **DART end date**: the date the patient is medically fit for surgery.
Missed Consultation/Surgery		
Definition	**Examples**	**Instructions**
The patient is not present for the first consultation/surgery at the scheduled date and time and as a result the consultation/surgery has to be rescheduled.	Patient does not inform the office that they will not be able to attend their scheduled consultation/procedure. Patient was three hours late for their consultation and as a result it has to be rescheduled.	One day DARC/DART is applied for the day the consultation/surgery was missed. The rationale for this patient delay being captured as 1 day is it helps identify cases which may have extended wait times due to a patient's missed procedure and lack of advance cancellation notice.
Pre-Defined Follow-Up Interval		
Definition	**Examples**	**Instructions**
The clinician has made the DTT but determines that the procedure is required at a clinically defined point in the future. This could include a follow-up in three months or a cancer re-check in one year. The clinician determines that the first consultation is required at a clinically defined point in the future. This could include waiting for medical clearance by an internist or accommodating the coordination of multiple services.	Patient is scheduled to come in for papilloma surgery every six weeks. Between the subsequent procedures, the patient does not see the clinician for additional consultation.	For the initial procedure there were no patient-related periods of unavailability, DARTs are not applicable. For each of the subsequent procedures, DART start date is the original DTT Date. **DART end date**: the day prior to the follow-up procedure date.
	Person with disabilities has a DTT for dental maintenance. The initial procedure takes place and a follow-up procedure takes place every year thereafter. Between the subsequent follow-up maintenance procedures, the patient does not see the dental surgeon for additional consultation.	For the initial procedure there were no patient-related periods of unavailability, DARTs are not applicable. For each of the subsequent procedures, DART start date is the original DTT Date. **DART end date:** the day prior to the follow-up procedure date.

	Clinician and patient have a consultation and agree surgery is required but patient must stop smoking for three months prior to surgery. The DTT Date is the date the clinician and patient decide to proceed with surgical treatment at the initial consultation.	**DART start date**: the date of the DTT. **DART end date**: the end date of the three-month interval.
	Diagnostic surgical procedures for cancer rechecks.	**DART start date**: the date of the DTT. **DART end date**: the date prior to the diagnostic procedure.
Neo-Adjuvant Chemotherapy		
Definition	**Examples**	**Instructions**
The patient requires chemotherapy before the procedure.	Patient has a confirmed procedure date but becomes ill and as a result requires other ongoing oncology-based medical treatments with another clinician.	**DART start date**: the date it was determined oncology-based medical treatments were required. **DART end date**: the date the patient is medically fit for surgery.
Neo-Adjuvant Radiation Therapy		
Definition	**Examples**	**Instructions**
The patient requires radiation therapy before the procedure.	Patient has a confirmed procedure date but becomes ill and as a result requires other radiation-based treatment with another clinician.	**DART start date**: the date it was determined radiation-based treatments were required. **DART end date:** the date the patient is medically fit for surgery.

Table 10: DART and DARC Definitions and Examples

System Delays

System Delays are flags within a patient's waitlist entry that provide further context around the reasons for extended wait times but are not subtracted from the wait time calculation.

System Delay fields were introduced as a means of gaining more information about **non-patient related delays that impact the patient's wait time**. It is up to facilities to determine the thresholds for reporting a system delay to the WTIS. The capture of system delays is intended to help with the analysis around extended waits particularly when facilities are asked to respond to questions from the ministry or LHIN.

System Delays can be edited in accordance with regular waitlist entry editing rules. If the initial waitlist entry indicated none were applicable, the entry can be edited at a later date to indicate updates.

Wait 1 System Delay: Healthcare system delays that are non-patient related and impact the patient's wait time for a first consultation. The delays may include clinician unavailability, limited clinic time, or lack of referral information (Table 11). **These delays will not be subtracted from the overall Wait 1**.

Wait 2 System Delay: Healthcare system delays that are non-patient related and impact the patient's wait time for a procedure. The delays may include clinician unavailability, limited OR time or bed unavailability (Table 11). **These delays will not be subtracted from the overall Wait 2**.

System Delay	Definition	Examples
Clinician Unavailability	The first consultation/procedure is delayed due to clinician unavailability. This could include absence due to vacation or lack of available appointments in the clinician's schedule.	• Procedure requires two clinicians to be present, but one is unavailable until a later date. • Patient requires reassessment prior to surgery because the clinician has a long wait time. • Clinician is on vacation during March Break. • Clinician takes a sabbatical and there is no replacement coverage. • Clinician takes a leave of absence (LOA).

System Delay	Definition	Examples
Patient Preference	The first consultation/surgery is delayed due to the patient's choice to remain on the waitlist of a particular clinician or at a particular location despite being offered the option of an earlier consultation or surgery with another clinician.	• Patient chooses to wait for a particular clinician or clinician who performs a particular procedure. • Clinician takes a LOA but the patient chooses to wait for the clinician to return, rather than have the surgery performed by the surgeon who is covering the LOA. • Patient who chooses to wait longer to have minimally invasive surgery such as robotic prostate surgery.
Prerequisites Not Completed	The first consultation is delayed due to missing or incomplete referral information. This could include incomplete labs or tests that delay the consultation. The procedure is delayed due to missing or incomplete patient information. This could include incomplete labs or tests that are required prior to the procedure.	• Some of the information needed to process the referral is missing. The original date the referral was received is still reported. • Patient requires medical imaging and/or other workup (e.g., cardiac workup) before the initial consultation. • Stent graft required for an aortic aneurysm repair will take two months for delivery and the surgery can be completed within two weeks of receipt of the stent graph. • Surgery is postponed or cancelled due to a lack of donor tissue. • A DTT has been reached for a patient who has other health issues and must undergo an assessment by a specialist before the surgery can take place. • A patient and clinician make a DTT but before the procedure can be booked, the patient requires a medical assessment to determine insurance coverage for travel cost.

System Delay	Definition	Examples
		• A dental surgeon and patient make a DTT but the procedure is required to be approved financially before being performed. • Patient must first go to a PAC (Patient Assessment Clinic) for a pre-op physical (i.e. Anaesthetic consultation, blood work, x-ray). • Patient has a DTT but cannot undergo surgery because post-operative care arrangements were not available.
Lack of Facility Resources	The first consultation/surgery is delayed due to unavailability of non-clinician staff or reductions to operating hours.	• Patients wait longer for surgery because procedure volumes are limited due to funding or supply issues. • Clinician has several procedures booked on one day but runs out of OR time because of slow turnaround preparing the OR between surgeries. • Half the team responsible for OR turnover is sick and the clinician is unable to perform all of the scheduled procedures because they run out of OR time. • Procedure delayed due to ORs closed during holiday periods. • Procedure delayed due to lack of resources generally kept in stock. • Procedure cannot take place until the radiologist confirms availability for wire insertion. • Last minute surgery cancellation due to equipment failure.

System Delay	Definition	Examples
Emergency Closures	The first consultation/surgery is delayed due to unforeseen unavailability of healthcare resources. This could include closures due to infectious outbreaks, extreme weather or other emergency situations.	• Patient's surgery date was rescheduled due to a C. Difficile outbreak at the facility where the surgery is to take place. • Due to the H1N1 outbreak, a consultation was rescheduled.
Rescheduled Due to Higher Priority Case	The first consultation/procedure is delayed to accommodate a higher priority patient.	• A patient is booked for surgery but their surgery date is rescheduled so that the clinician can operate on a more urgent patient.

Table 11: System Delay Definitions and Examples

Patient Chooses to Defer (DART/DARC) versus Patient Preference (System Delay)

A **Patient Preference System Delay Reason** is entered for a case in which the patient chooses to wait for a particular clinician or clinician who performs a particular procedure. It is intended to capture those patients waiting for a particular specialist, facility, or technology, since that resource is either limited or specialized in some fashion. An example of this would be a minimally invasive bladder surgery that is only offered at two facilities in the province since only three surgeons have been trained on this technique. Even though the patient could have an open procedure at many other facilities in the province more quickly, the patient prefers to wait for the less invasive approach and so the wait time is extended.

Since the System Delay function does not subtract any time from the waitlist entry, it allows for an accurate picture of how long the patient is actually waiting for the procedure. This also allows for analysis to indicate there is an extenuating circumstance why this procedure has a longer than average wait time. The intention is to eventually monitor trends that would help identify areas requiring development or additional resources.

The **DART/DARC Patient Chooses to Defer** results from a patient being unavailable for the first consultation/procedure due to personal reasons (such as a vacation or a death in the family), personal preferences for the date and time of the consultation, or weather reasons (such as road and airport closures).

Decision to Treat (DTT)

The Decision to Treat date (DTT) is the date both the clinician and patient agree to surgery. The agreement can be established either verbally or in a written form depending on the hospital's process.

To be placed on an official waitlist a patient must have a condition/disease of sufficient severity to fall into one of the four categories of the Priority Assessment Tools. Patients who have not reached a minimum of Priority Level 4 severity in condition, should not be put onto the waitlist. If the patient is not yet "ready to treat", but only has the possibility of requiring surgery at a later time, they have not had a true DTT and should not have an open waitlist entry in the WTIS.

DTT Scenarios

The date of the DTT may not always be straightforward in different models of care. Table 12 provides some scenarios and guidance on how to report the DTT.

DTT Scenario	Example	DTT Date
Clinician other than a surgeon makes a DTT	Internal specialist reviews a referral on June 1, 2016 to determine whether a patient is suitable for surgery, in lieu of a surgical consultation.	**DTT date:** the date the internal specialist determines the patient is suitable for surgery: June 1, 2016.
	Vascular clinician consults with a patient and a consent form is signed indicating that the patient may require vascular access surgery for dialysis in the future. The patient is thereafter followed by a nephrologist who will later determine on April 15, 2016 that the patient requires surgery and the patient agrees. The nephrologist contacts the clinician to request that the patient be booked for surgery.	**DTT date:** the date when the nephrologist determines that the patient requires the surgery and the patient agrees to proceed to surgery: April 15, 2016.
	Before a patient is seen by a surgeon on the day of their lithotripsy procedure, they are assessed by a nurse via telephone on January 5, 2017 to determine whether they are cleared to come in for the procedure. Based on the telephone call, the nurse determines lithotripsy is required.	**DTT date:** the date of the telephone assessment as the RN is working under the medical directive of the clinician: January 5, 2017.

DTT Scenario	Example	DTT Date
Patient Transferred Between Surgeons	Patient makes a DTT with a specialist on May 2, 2015 but is transferred to another specialist for surgery. The second specialist's assessment of the patient does not change and surgery is booked.	**DTT date:** the date the first specialist and patient agreed to surgery: May 2, 2015. The original clinician should close their waitlist entry, indicating why the procedure is no longer required. The new clinician should create a new waitlist entry for the patient, ensuring the original DTT date is maintained.
	Patient makes a DTT with a specialist on May 30, 2016. Later, the specialist refers the patient to another clinician, and the new clinician's assessment determines a different treatment plan for the patient on July 15, 2016 and the patient agrees (e.g., patient's priority level has changed or the clinician determines that a different procedure is required).	**DTT date:** the date of the reassessment by the second clinician. The original clinician should close their waitlist entry, indicating why the procedure is no longer required. The new clinician should create a new waitlist entry for the patient, using the new DTT date.
Delayed DTT	On June 10, 2015 a clinician requests an OR date for a patient but the clinician does not make a decision as to whether to proceed until the day of the surgery, June 30, 2015.	**DTT date**: the date the clinician booked the OR for the procedure: June 10, 2015.
	On May 1, 2016, a surgeon advises their patient surgery will be required but the patient does not consent to surgery until a reassessment appointment 3 months later, on August 2, 2016.	**DTT date**: August 2, 2016 when the patient consents.

DTT Scenario	Example	DTT Date
DTT for a Difference Procedure	A patient and clinician may make a DTT for one procedure on January 10, 2015, but later a different procedure is decided upon for the same surgery date.	**DTT date:** remains the same, January 10, 2015 because it represents the start of the patient's wait time for the original procedure to treat the same condition. The waitlist entry should be updated with the new procedure to reflect the change in the treatment.
	A patient and clinician may make a DTT for one procedure on February 11, 2015, but later a different procedure is decided upon on March 15, 2015 and a different surgery date is required because the procedure requires a different OR set-up.	**DTT date:** March 15, 2015 because a significantly different procedure has been agreed upon. The original waitlist entry should be cancelled using one of the Procedure No Longer Required Reasons depending on the situation: Cancelled by Patient; Improved Medical Condition; or No Longer Medically Stable. A new waitlist entry would then be opened with the new procedure and the new DTT date.
DTT made outside the surgeon's office	Surgeon and a patient make a DTT in a hospital clinic on April 2, 2016.	**DDT date:** April 2, 2016 when the surgeon's office reports the surgery in the WTIS.

Table 12: Decision to Treat (DTT) Scenarios

Editing or Updating Waitlist Entries

Transferring Patients to Different Clinicians, Sites or Facilities

If a patient begins a wait at one site of a facility but the procedure is completed at another site of the same facility, then the waitlist entry is updated as soon as possible indicating the new site.

If a patient begins a wait with one clinician at the facility but is later transferred to the care of another clinician at the same facility, two scenarios must be considered:

Scenario 1: If the new clinician assesses the patient and determines the same priority assessment as the original clinician (e.g. that the patient's priority level is the same as when their waitlist entry was opened), then a user with WTIS access to the original clinician should close the waitlist entry by selecting Procedure No Longer Required and choosing the Procedure Completed Elsewhere reason. A user with access to the new clinician would then open a new waitlist entry including the new clinician, using the original DTT date. .

Note: If the user has WTIS access to both the original clinician and the new clinician, they may simply edit the clinician name in the existing waitlist entry. If Wait 1 data was available in the original clinician's waitlist entry, the original Wait 1 Referral Date and Consult Date should continue to be used. If Wait 1 data was not available in the original clinician's waitlist entry, the new clinician's waitlist entry would also report no Wait 1 data using the Referral Type of No Referral/Follow-Up.

Scenario 2: If the new clinician assesses the patient and determines the priority assessment of the patient differs from the original assessment (e.g. that the patient's priority level has changed since their waitlist entry was opened), then a user with WTIS access to the original clinician should close the waitlist entry by selecting Procedure No Longer Required and choosing the Procedure Completed Elsewhere reason. A user with WTIS access to the new clinician would then open a new entry including the new clinician, the new priority level, and using the reassessment date as the DDT date. The new waitlist entry should be opened within 2 business days of the reassessment date.

Note: If the user has WTIS access to both the original clinician and the new clinician, they may simply edit the physician name and priority level in the existing waitlist entry. The appointment with the new clinician that results in a reassessment and new priority level would be reported as new Wait 1 data. The new clinician's waitlist entry would report a Referral Type of ReReferral; the Referral Date is the date the patient was transferred to the new surgeon; and the Consult Date is the reassessment date.

If a patient begins the wait at one facility but the clinician changes the OR location to a completely different facility, then the first facility closes the initial waitlist entry and the new facility opens a new waitlist entry using the original Wait 1 and DTT data. The 2-business day rule for opening this waitlist entry will be affected.

Cancelling Waitlist Entries Because the Patient Cannot be Contacted

If the clinician's office has been unsuccessful in contacting the patient with an available surgery date, they should wait for one year before closing a waitlist entry with a reason of Procedure No Longer Required. At this point it would be likely the patient had the procedure completed elsewhere or no longer requires the procedure for some other reason.

Edit Priority Level

If the clinician has determined that a patient's priority level has changed, the waitlist entry would be updated with the new priority level.

Priority levels and descriptions should cover approximately 95% of cases. In the 5% of cases where the descriptions and priorities do not match, the priority override function will allow the treating clinician to correctly capture the description with a different priority. For example, if the patient has symptoms described in Priority Level 4, yet the impact is more severe based on the patient's age, the clinician can upgrade the priority level to Priority Level 3 while capturing the correct statement.

Planned Versus Unplanned Procedures

Incidental (unplanned) surgeries are not reported in the WTIS (appendectomy incidental to larger surgery).

If a patient is in the OR for a planned surgery but the procedure is converted to a different type of surgery or was cancelled, the wait time should be captured for the intended (scheduled) procedure. The wait time should be reported in the WTIS using the intended (planned) procedure because the patient waited for access to the OR and associated resources for the intended (planned) procedure. The following are examples of such scenarios:

- Patient booked for hip replacement surgery, but after patient arrives in the OR an infection is found in the current implant, resulting in irrigation and debridement of the wound. The hip replacement surgery should be reported in the WTIS as it was the planned procedure.
- Patient booked for hip replacement surgery but patient has an ineffective anesthetic block. The hip replacement surgery the patient waited for is reported, and if the clinician decides the patient is ready for surgery at a later time then a new waitlist entry for the patient would be created once the clinician has decided that the patient is ready for surgery, with a new DTT and Wait 1 data if applicable.
- A clinician begins an oncology treatment procedure and during surgery it is determined that the procedure will only be palliative in nature. The treatment oncology procedure is reported as it was the planned procedure.
- A patient was scheduled for bariatric surgery but once in the OR the procedure was changed to a diagnostic laparotomy. The bariatric surgery is reported as it was the planned procedure.

Referral Source

The Referral Source data element has three possible options for entry: Central Intake, DAP/Unit and Other.

Central Intake

Central Intake is defined as a model of care that utilizes a single process to facilitate a patient's access to specialized care across multiple hospitals or within the same hospital. Also, it is possible a patient could be referred through central intake to a surgeon in the same hospital that houses the central intake unit.

Central intake can be selected as the Referral Source for all service areas if it is utilized as a single process to facilitate patient access to specialized care. The following are examples of such models:

- Rapid Access Clinics (RACs)
- Regional Joint Assessment Centre
- Fracture clinic that controls access to surgeons can be a central intake since the centre is using a single process to facilitate the patient's access to specialized care.
    - The fracture clinic may triage patients for a variety of orthopaedic surgery areas (shoulder, foot, hip, knee).
- OBSP centres that coordinate the patient's first consultation with the surgeon can be considered a central intake since the centre is using a single process to facilitate the patient's access to specialized care

For the Referral Source monthly compliance indicator, only the monthly volumes of hip and knee replacement surgery are included in the facility's Referral Source volume target.

In a central intake model, the Referral Date is the date the central intake receives the referral and the Consultation Date is the date of the patient's *first* consultation with a surgeon (or a delegate if that delegate has been assigned the authority to make a decision to treat surgically. For example a nurse practitioner who has been delegated the authority to make a decision to treat on behalf of the surgeon). If the patient has multiple consultations with other surgeons, the Consult Date would be the date when the patient had their *first* consult with a surgeon. If the assessment centre model requires that the patient undergoes physiotherapy or other conservative management prior to seeing a surgeon, DARCs can be reported to cover the period of patient unavailability, with a reason of Change in Medical Status.

For further information regarding Central Intake data capture specific to MSK please contact ATCsupport@ontariohealth.ca.

Diagnostic Assessment Program (DAP)

The DAP/Unit coordinates the patient journey from referral for suspicion of cancer to a definitive diagnosis. They include the full spectrum of multidisciplinary diagnostic testing in an environment focused on the patient.

DAP cannot be selected as a Referral Source unless the Service Area is Surgical Oncology and SD 1 is Colorectal, Prostate or Lung (currently the only designated DAPs in Ontario). If a waitlist entry does not meet these criteria but the patient still proceeds through an assessment centre before they can access specialized care, Central Intake should be selected as the Referral Source.

If a patient was consulted by a surgeon through the DAP, the Referral Date would be the date when the referral was received by DAP. The Consultation Date would be the date when the patient had their *first* consult with a surgeon within the DAP (or a delegate if that delegate has been assigned the authority to make a decision to treat surgically. For example a nurse practitioner who has been delegated the authority to make a decision to treat on behalf of the surgeon). In a scenario where a surgeon who consults with a patient and either refers the patient to themselves and or another surgeon for surgery within the DAP, the consultation date is considered the date that the patient had their consultation with the first surgeon. Referral Type would either be New Referral or ReReferral depending on how the patient was referred within the DAP. The DTT Date would be the date when a surgeon and the patient both agree to proceed with the surgery.

Other

The Referral Source of Other is used to describe the origin of a patient's referral for all other instances that do not meet the definition of a Central Intake or DAP.

Referral Type

There are three Referral Types in the WTIS:

- New Referral
- ReReferral
- No Referral/Follow-Up

The Referral Type selected should reflect the patient's status as of the date of the first consultation with the clinician who makes the DTT.

New Referral

New Referral is a referral for a patient who is seeing a clinician for the first time or an existing patient with a new referral to the same clinician. New Referral applies to the majority of patients, usually around 70% of surgical patients.

The following are some New Referrals scenarios:

- A clinician has been seeing a patient for years for a recurring condition, and sometimes the patient will go a year without being seen in the office. In this case the office requires a referral for the patient from the family doctor again.
- A patient was referred by their family physician but the referral to the clinician was cancelled. After further tests, another referral was sent to the clinician and the patient has a consultation.
- A new referral was received by a clinician for suspected prostate cancer and the patient had a consultation with the clinician. The patient initially has negative biopsies and is monitored for several years until a positive biopsy occurs and a DTT for surgery is made. The Referral Type is New Referral to reflect the patient's status as of the date of the first consultation.
- A patient is referred to an orthopaedic surgeon for a knee replacement. The clinician feels the procedure is not required until the patient is 65. The patient does not want to wait this long and asks their family physician to refer them for a second opinion. The family physician refers the patient to a second clinician for a consultation and the second clinician and patient decide to proceed with surgery. The Referral Type is New Referral. It is not a ReReferral because the patient is being referred from their family physician to a specialty clinician in both instances (first opinion and second opinion).
- Referrals from dentists to oral clinicians are considered New Referrals instead of ReReferrals because the referring dentist is not another surgeon.

ReReferral

ReReferral is defined as a referral for a patient who has already seen a surgeon or is seeking a second opinion (which includes secondary referrals for complex/staged procedures). ReReferral information can come directly from the patient during the initial consultation or it can be provided by the referring surgeon. Both intra-service referrals and inter-service referrals are considered ReReferrals.

The following are some ReReferrals scenarios:

- Patient is referred from dentist, who is also an oral surgeon, to another surgeon.
- Dr. Smith performs the initial procedure and then rerefers the patient to Dr. Feldman for the second stage of the procedure on a different date. The Referral Type for the second procedure is ReReferral.
- Patient referred from orthopaedic surgeon in the emergency department to another surgeon's office.
- Patient is referred from one surgeon to another surgeon within a Central Intake Assessment Centre (CIAC).

No Referral/Follow-Up

Wait 1 data should always be reported, with two exceptions:

1. Patients who did not require a referral for their surgical treatment procedure.
2. Rare instances where the referral date is not on the patient's chart.

In these scenarios the Referral Type, No Referral/Follow-Up would be selected. With this option selected, the user also selects a reason, and then no further Wait 1 data is required. There are three possible reasons available for selection in the WTIS and details follow in the next three subsections.

No Referral/Follow-Up Reason of Existing Patient (New Condition)

This reason includes the patient who returns to see the clinician with a new condition but has no new referral. It can also be a patient who has an unexpected surgery without a referral for consultation. Lastly, it can represent patients where the clinician identifies a new condition during follow-up visits for an existing condition.

The following are some No-Referral/Follow-Up Reasons of Existing Patents (New Condition) scenarios:

- Patient is referred to a specialist for a specific problem and then a new problem is discovered during the consultation for which surgery is required.
- Arthroscopy previously performed on left knee now scheduled to be performed on the right knee. (As the second staged procedure will be on a different body part, it represents a new condition that the clinician is treating for an existing patient).
- Cataract surgery previously performed on left eye now scheduled to be performed on the right eye. (As the second staged procedure will be on a different body part, it represents a new condition that the clinician is treating for an existing patient).

- A patient has dental surgery to repair a cavity. Later, the patient requires surgery for a cavity on a different tooth.
- Patient has an existing referral and consultation date for a medical condition (e.g. glaucoma), but then develops a second medical condition (e.g. cataract) during treatment for the glaucoma. No Referral/Follow-Up Reason of Existing Patient (New Condition).

No Referral/Follow-Up Reason of Existing Patient (Recurring Condition)

This reason describes a patient who returns for ongoing care for a recurring condition (second, third, fourth surgical treatments). It can also represent patients followed for a number of years before a DTT for surgery is made yet Wait 1 data is unavailable. The following are some No-Referral/Follow-Up Reason of Existing Patents (Recurring Condition) scenarios:

- A patient was previously surgically treated and is returning for surgical treatment for an existing condition with the same clinician and without a new referral
- A patient has a series of staged procedures but are **not** for a new or chronic condition
- A patient has dental surgery to repair a cavity and later the same tooth develops another cavity and requires dental surgery
- A patient has periodontal disease which requires recurring surgery for ongoing issues

No Referral/Follow-Up Reason of New Patient (No Referral)

This reason describes a patient with no referral or who self-referred for a consultation. The following are some No Referral/Follow Up Reasons of New Patient (No Referral):

- A patient sees Dr. White for a surgical consultation but did not have a referral
- A patient sees Dr. White in his walk-in clinic and Dr. White tells the patient to book a consultation with him

Responsibility for Payment

The collection of Responsibility for Payment data provides an understanding of funding sources for procedures captured in the WTIS. There are three possible selections for this data element:

1. **Provincial Government/OHIP Payment** is made by the Ontario Health Insurance Program and refers only to Ontario
2. **Private Coverage Payment** is made by patients paying for services out of pocket or through private insurance coverage
3. **Other Payment** is made by federal government programs including:
    - Veterans Affairs Canada (VAC), First Nations and Inuit Health
    - Branch, RCMP Department of National Defense, penitentiary inmates or immigration
    - Payment is made by a worker's service insurance board (e.g., WSIB or WCB, etc.), other province or territory insurance plans in Canada (other than Ontario)

In a case where two or more sources are providing funding for a procedure, Responsibility for Payment would be the option which represents the majority of the funding. If the source of the majority of the funding cannot be determined, it is recommended this information not be entered until it has been confirmed.

Appendix A: Wait 1 and Wait 2 Case Studies

Case Study 1: Wait 1 – New Referral

Case Study 2: Wait 1 – New Referral

Case Study 3: No DTT

Case Study 4: No Wait 1 for Diagnostic Imaging

Case Study 5: Wait 1 – No Referral/Follow-Up

Case Study 6: Wait 1 DARC – Developmentally Appropriate Wait

Case Study 7: Wait 1 DARC – Missed Consultation

Case Study 8: Wait 1 DARC – Patient Chooses to Defer

Case Study 9: Multiple DARCs

Case Study 10: Wait 1 System Delay – Emergency Closures

Case Study 11: Multiple DARTs

Case Study 12: Wait 1 and Wait 2 with DART – Inability to Contact Patient

Case Study 13: Wait 2 System Delay – Surgeon Unavailability

Case Study 14: Wait 2 System Delay – Patient Preference

Case Study 15: Wait 2 – Low Probability of Cancer

Case Study 16: Wait 2 – Fully Functional OR

Case Study 17: Wait 2 – Emergency Surgical Oncology

Case Study 18: Wait 2 – Paediatric Surgery

Case Study 19: Wait 1 and Wait 2

Case Study 20: Cancer Reconstructive Surgery

Case Study 21: Cancer Palliative Surgery

Case Study 22: Cancer Diagnosis Surgery

Case Study 23: Diagnostic Surgery and Treatment Surgery with the Same Clinician

Case Study 24: Wait 1 and Cancer Screening

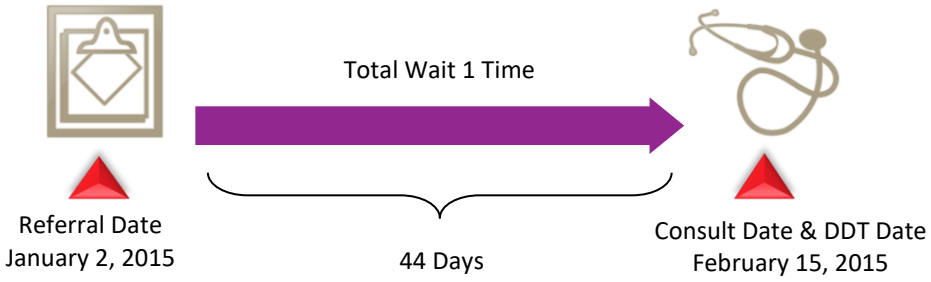
Case Study 25: Prophylactic Surgery

Case Study 26: Cancer Preparation Surgery

Case Study 27: Combination Procedures that are Clinically Related

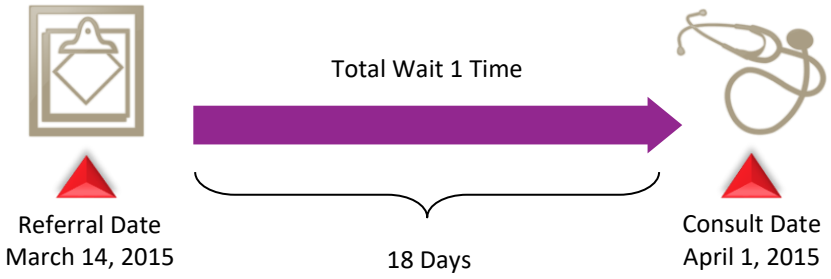
Case Study 28: Concurrent Procedures that are not Clinically Related

Case Study 1: Wait 1 – New Referral	Data Element	Reference Data
Frank is a 50-year-old male with a persistent cough. Concerned with a large lung mass on Frank's MRI scan, his primary care physician refers him to Dr. Cue, a Thoracic Surgeon. Dr. Cue's office received the referral on January 2, 2015 and assigned a Wait 1 Priority Level 2 to Frank. The consultation occurred on February 15, 2015. During the consultation, Frank agreed to Dr. Cue's recommendation to be treated with surgery.	Referral Type	New Referral
	Referral Source	Other
	Referral Date	January 2, 2015
	Consult Date	February 15, 2015
	Wait 1 Priority Level	Priority 2
	Decision to Treat Date	February 15, 2015



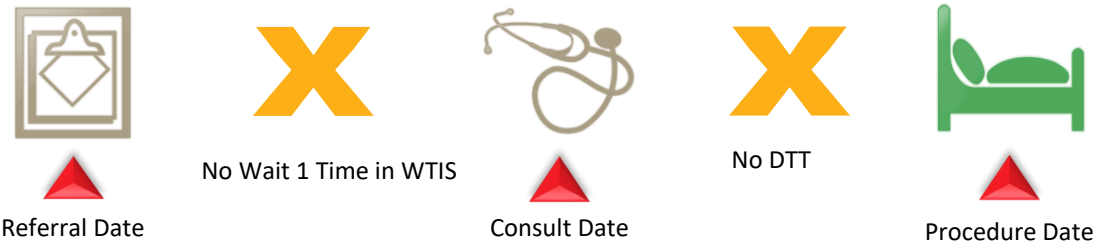
Key Principle
Wait 1 data is captured for a patient waiting for a surgical consultation.

Case Study 2: Wait 1 – New Referral	Data Element	Reference Data
Vincent is a 54-year-old male who suffered an ischemic stroke. His primary care physician referred him to Dr. Deelait, a Neurosurgeon for a possible carotid endarterectomy surgery. Dr. Deelait's office received Vincent's referral on March 14, 2015 and he is assigned a Wait 1 Priority Level 2. The consultation occurred with Dr. Deelait on April 1, 2015 who at the time recommended surgery and asked Vincent to think about proceeding with surgery, asking Vincent to phone the office within the week with his decision. On April 5, 2015, Vincent phoned Dr. Deelait's office confirming his decision to be treated.	Referral Type	New Referral
	Referral Source	Other
	Wait 1 Priority Level	2
	Referral Date	March 14, 2015
	Consult Date	April 1, 2015
	Treating Healthcare Professional	Dr. Deelait
	Decision to Treat Date	April 5, 2015



Key Principle
Wait 1 data will be retrospective and captured at the same time as the Decision to Treat is made.

Case Study 3: No Decision to Treat (DTT)	Data Element	Reference Data
Sammy is a two-year-old male. After having two episodes of otitis media with effusion Sammy's primary care physician referred Sammy to Dr. Iantea, an Otolaryngologist, on April 3, 2015. Dr. Iantea felt that Sammy had not had recurrent episodes, which would warrant ear surgery for tympanostomy tube placement. Accompanied by his parents, Sammy was seen for a consultation. Surgery was not recommended.	Referral Type	Not Applicable
	Referral Source	Not Applicable
	Referral Date	Not Applicable
	Consult Date	Not Applicable
	Wait 1 Priority Level	Not Applicable
	Decision to Treat Date	Not Applicable



Key Principle
Wait 1 only captured when there is a Decision To Treat (DTT) for surgery.

Case Study 4: Wait 1 – No Wait 1 for Diagnostic Imaging	Data Element	Reference Data
Thomas is an elderly male who presented with severe persistent abdominal pain, difficulty swallowing and a loss of appetite to his primary care physician. Thomas was referred to Dr. French an internist and was seen on April 17, 2015. Dr. French made the decision to send Thomas for an MRI scan in order to investigate his symptoms for suspected stomach cancer. He was booked for his scan on April 20, 2015. There was no DTT for surgery.	Referral Type	Not Applicable
	Referral Source	Not Applicable
	Referral Date	Not Applicable
	Consult Date	Not Applicable
	Treating Healthcare Professional	Not Applicable
	Decision to Treat Date	Not Applicable

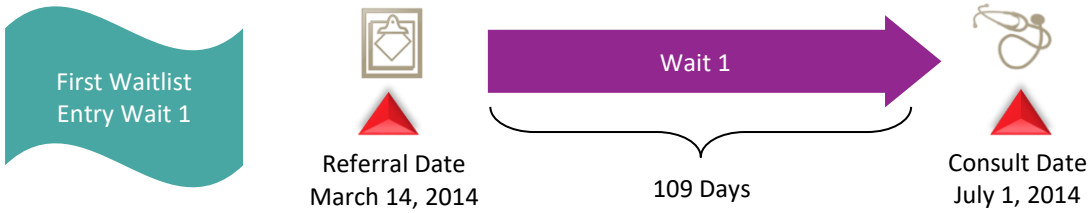
Referral Date

No Wait 1 Time in WTIS

Consult Date

Key Principle
Wait 1 collection is mandatory for surgery; Wait 1 does not apply to diagnostic imaging.

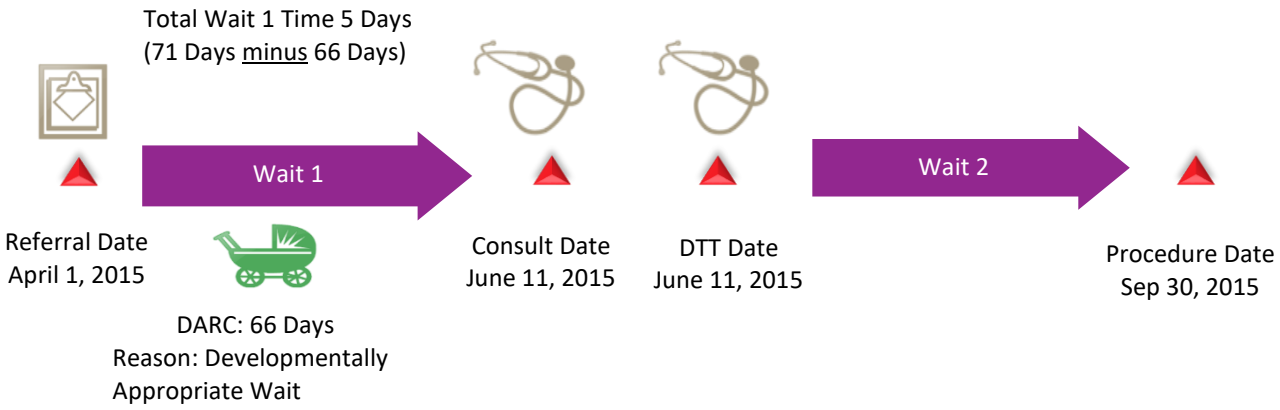
Case Study 5: No Referral / Follow-Up	Data Element	First Waitlist Entry	Second Waitlist Entry
Jorge is referred to Dr. Bloom, an Orthopaedic Surgeon for severe pain in the right knee. Dr. Bloom's office received Jorge's referral on March 14, 2014, and the consultation occurred on July 1, 2014. During the consultation, Dr. Bloom determined that both knees would require surgery and recommended bilateral knee replacement surgery. A decision to treat was made July 5, 2014 for the first knee. The first surgery took place December 5, 2014. For the second surgery, a DTT took place on January 1, 2015 and the surgery took place April 5, 2015.	Referral Type	New Referral	No Referral / Follow-Up
	Referral Source	Other	Not applicable
	Wait 1 Priority Level	3	Not applicable
	Referral Date	March 14, 2014	Not applicable
	Consult Date	July 1, 2014	Not applicable
	Treating Healthcare Professional	Dr. Bloom	Not applicable
	Decision to Treat Date	July 5, 2014	January 1, 2015
	Procedure Date	December 5, 2014	April 5, 2015



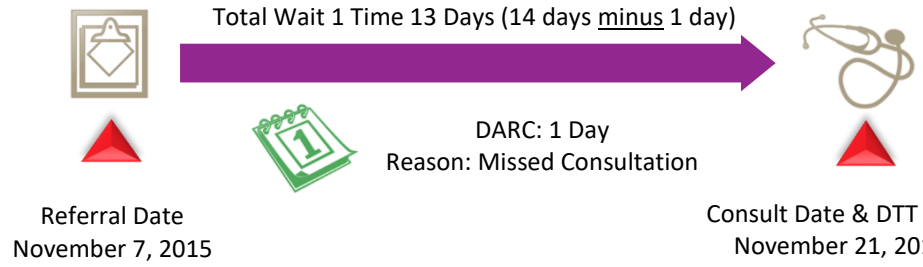
Wait 2 is reported only.

Key Principle
Wait 1 data is not reported for cases where there is no new referral.

Case Study 6: Wait 1 DARC – Developmentally Appropriate Wait	Data Element	Reference Data
Stephen, a week-old newborn, was born with a cleft palate and was referred to Dr. Simpson, an Otolaryngic Surgeon, for a consultation on April 1, 2015. Due to Stephen's young age, Dr. Simpson felt the consultation should wait until Stephen reached the age of 10 weeks (June 6, 2015); a developmentally appropriate age. At that time options to repair his cleft palate with surgery would be discussed. Given the information he has received about Stephen, Dr. Simpson feels Stephen is an appropriate candidate for a surgical repair. Stephen is booked for a consultation on June 11, 2015. Stephen's parents agree with Dr. Simpson's recommendation to proceed with surgery and a decision to treat is made. Dr. Simpson's assistant enters a Date Affecting Readiness to Consult (DARC) reason of Developmentally Appropriate Wait for Stephen for 66 days (April 1 to June 6).	Referral Type	New Referral
	Referral Source	Other
	Referral Date	April 1, 2015
	Consult Date	June 11, 2015
	DARC From Date	April 1, 2015
	DARC To Date	June 6, 2015
	DARC Reason	Developmentally Appropriate Wait
	Treating Healthcare Professional	Dr. Simpson
	Decision to Treat Date	June 11, 2015

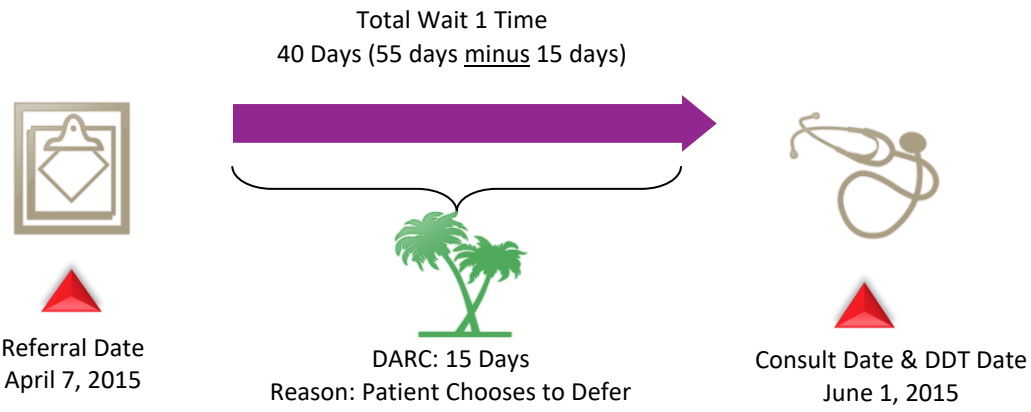


Case Study 7: Wait 1 DARC – Missed Consultation	Data Element	Reference Data
Paul's referral was sent from his primary care physician to Dr. Evans for a surgical consultation on November 7, 2015. Paul's consultation is scheduled for the morning of November 20, 2015. As Paul has a history of dementia, he forgets to record his appointment on his calendar at home and misses his appointment with Dr. Evans. Dr. Evans' office reaches Paul by phone the afternoon on November 20, 2015, and reschedules the consultation for November 21, 2015. During this appointment, Dr. Evans recommends surgery, Paul agrees, and a decision to treat is made. Dr. Evans' office enters a DARC Reason of Missed Consultation. The time period would be 1 day for the missed consultation.	DARC From Date	November 20, 2015
	DARC To Date	November 20, 2015
	DARC Reason	Missed Consultation
	Treating Healthcare Professional	Dr. Evans
	Decision to Treat Date	November 21, 2015



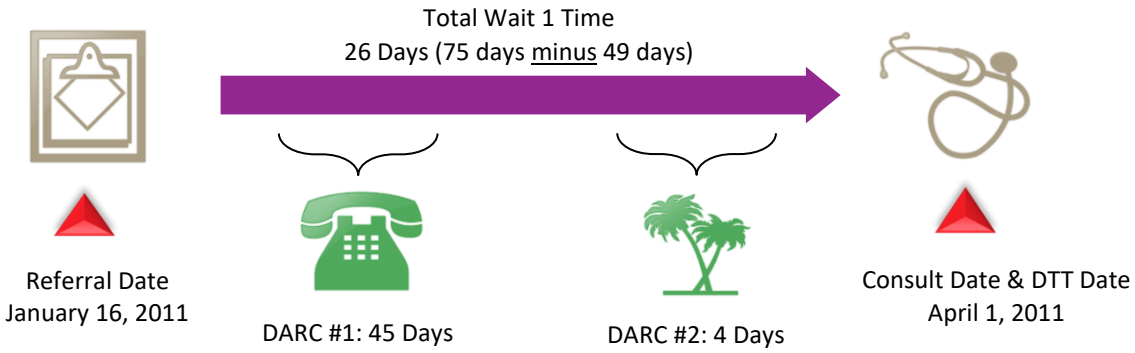
Key Principle
DARCs will be subtracted from the overall Wait 1 period.

Case Study 8: Wait 1 DARC – Patient Chooses to Defer	Data Element	Reference Data
Rose's referral was sent to an Orthopaedic Surgeon, Dr. Back, who received the referral on April 7, 2015. Rose is offered a consult date for May 1, 2015 but indicates she will not be able to attend on this date since she will be attending a wedding out of town from May 1, 2015 to May 15, 2015. She is instead scheduled for a consultation on June 1, 2015. Rose attends her consultation on June 1, 2015. Dr. Back recommends surgery, Rose agrees, and a decision to treat is made.	DARC From Date	May 1, 2015
	DARC To Date	May 15, 2015
	DARC Reason	Patient Chooses to Defer
	Treating Healthcare Professional	Dr. Back
	Decision to Treat Date	June 1, 2015



Key Principle
DARCs are patient-related delays captured and tracked in the WTIS.

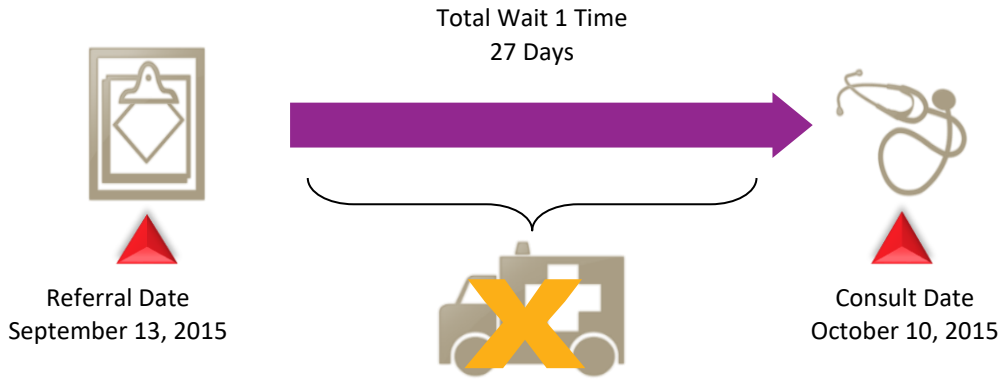
Case Study 9: Multiple DARCs	Data Element	Reference Data
Gina's referral was sent from her primary care physician to Dr. Poole's office on January 16, 2011. Dr. Poole's office tried to reach Gina but was unable to contact her. After Dr. Poole's office made a reasonable effort to contact Gina, Dr. Poole's assistant began to apply a DARC time fromJanuary 31, 2011 until March 16, 2011 when Gina contacted the office to arrange for her consultation. On March 16, 2011, Dr. Poole's office spoke to Gina and offered a consultation date of March 19. She informed the office that she would be away on vacation from March 17, 2011 until March 20, 2011. As a result, a second DARC was applied with the reason of Patient Chooses to Defer. Gina saw Dr. Poole on April 1, 2011, and during that appointment, she agrees to Dr. Poole's recommendation for surgery and a decision to treat is made.	DARC From Date #1	January 31, 2011
	DARC To Date #1	March 16, 2011
	DARC Reason #1	Inability to Contact the Patient
	DARC From Date #2	March 17, 2011
	DARC To Date #2	March 20, 2011
	DARC Reason #2	Patient Chooses to Defer



Key Principle
Multiple DARCs can be applied as necessary if more than one patient-related delay is affecting the same waitlist entry.

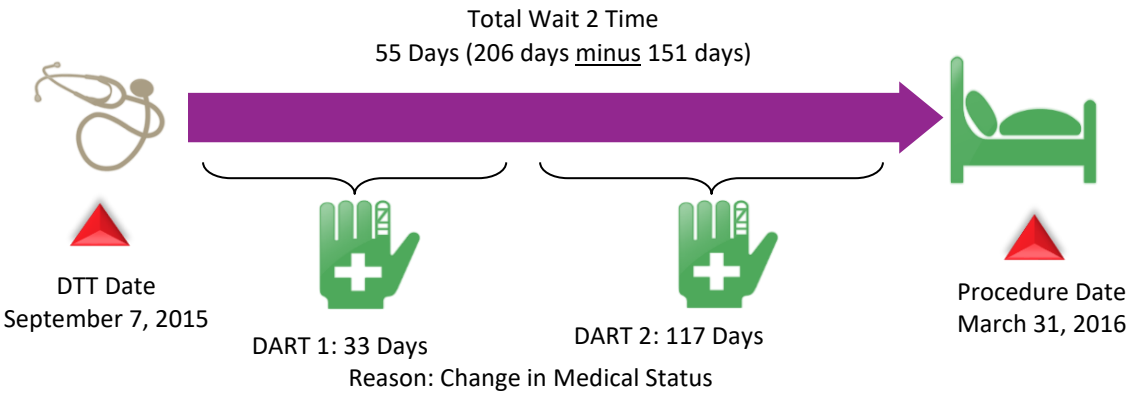
<table>
<tr><th>Case Study 10: Wait 1 System Delay – Emergency Closures</th><th>Data Element</th><th>Reference Data</th></tr>
<tr><td rowspan="2">One of Toronto’s downtown hospitals had an outbreak of H1N1 in the fall of 2015.

Martin, a 55-year-old male, was referred by his primary care physician to Thoracic Surgeon, Dr. Glass, for a consultation on September 13, 2015.

Due to the outbreak, the consultation was pushed to October 10, 2015 from the originally scheduled appointment on October 3, 2015.</td><td>Is Wait 1 System Delay Reasons applicable?</td><td>Yes</td></tr>
<tr><td>Wait 1 System Delay Reason</td><td>Emergency Closures</td></tr>
<tr><td colspan="3"> 

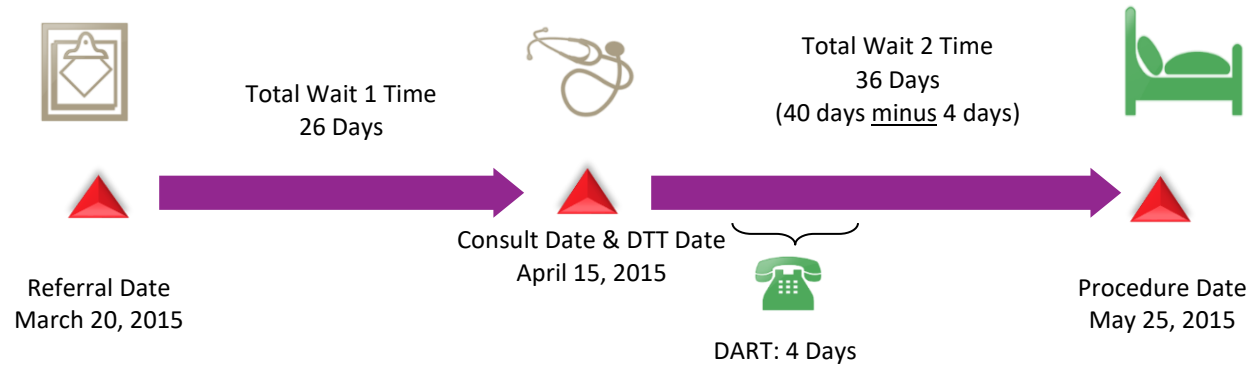
Key Principle
System delays are delays that are not patient-related.</td></tr>
</table>

Case Study 11: Multiple DARTs	Data Element	Reference Data
On September 7, 2015, a decision to treat is made for Grace, a 59-year-old female. On October 11, 2015, Grace develops severe pneumonia and cannot proceed with surgery. On November 13, 2015, the pneumonia has resolved and Dr. Kershaw deems Grace ready to proceed with surgery. Suddenly, Grace suffers a stroke on November 20, 2015. She must complete extensive rehabilitation and physiotherapy, and surgery is once again delayed until March 15, 2016. On March 31, 2016, the surgery is completed.	DART From Date #1	October 11, 2015
	DART To Date #1	November 13, 2015
	DART Reason #1	Change in Medical Status
	DART From Date #2	November 20, 2015
	DART To Date #2	March 15, 2016
	DART Reason #2	Change in Medical Status

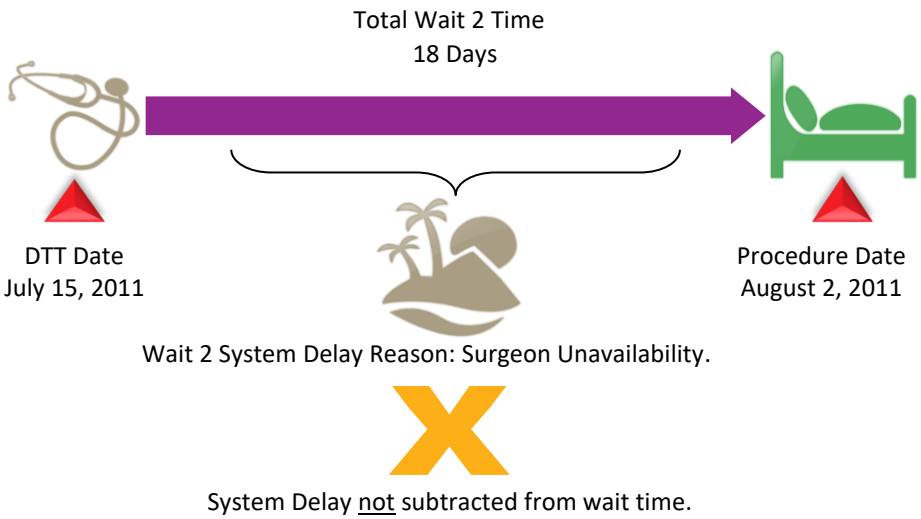


Key Principle
A DART is applied if a patient's medical status has worsened while waiting for surgery. Multiple DARTs may be applied for more than one patient-related delay affecting the same waitlist entry.

Case Study 12: Wait 1 and Wait 2 with DART – Inability to Contact Patient	Data Element	Reference Data
Lisa is a 70-year-old female with diabetes and is a long-time smoker who suffers from peripheral vascular disease. Her primary care physician referred Lisa to Dr. White on March 20, 2015, and she was seen for a consultation on April 15, 2015. During the consultation Dr. White explains to Lisa that a below knee amputation on the right leg is needed. A decision to treat is made on April 15, 2015, and Lisa is assigned as a Wait 2 Priority Level 3 case. Dr. White's office tried to reach Lisa to book surgery but was unable to contact her. Dr. White's assistant began to apply a DART from April 30, 2015 until May 3, 2015 when Lisa returned their call. Lisa is then informed that her procedure is scheduled for May 25, 2015.	Service Area	Vascular Surgery
	Service Detail 1	Amputation Surgery
	Service Detail 2	Below Knee
	Referral Type	New Referral
	Wait 1 Priority Level	2
	Referral Source	Other
	Referral Date	March 20, 2015
	Consult Date	April 15, 2015
	Treating Healthcare Professional	Dr. White
	Wait 2 Priority Level	3
	Decision to Treat Date	April 15, 2015
	DART From Date	April 30, 2015
	DART To Date	May 3, 2015
	DART Reason	Inability to Contact the Patient
	Scheduled Procedure Date	May 25, 2015
	Procedure Date	May 25, 2015

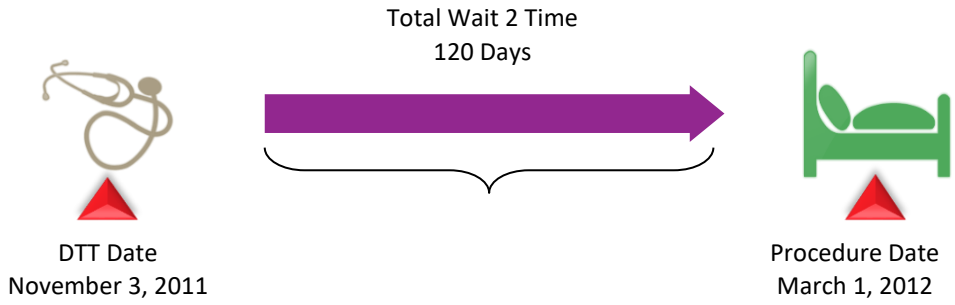


Case Study 13: Wait 2 System Delay – Surgeon Unavailability	Data Element	Reference Data
30 year-old Michael's referral was received by Dental Surgeon, Dr. Smile's office on July 2, 2011. It was sent by Michael's primary care physician. Michael was seeing Dr. Smile for a consultation about orthognathic surgery to treat his malocclusion as he was having difficulties closing his mouth. Dr. Smile saw Michael on July 15, 2011. Michael made his decision to be treated by Dr. Smile during the consultation. Michael was scheduled for his procedure on August 2, 2011, but could not be seen by Dr. Smile earlier as Dr. Smile was on vacation from July 20, 2011 to July 31, 2011.	Is Wait 2 System Delay Reasons applicable?	Yes
	Wait 2 System Delay Reason	Surgeon Unavailability



Key Principle
System delays are not subtracted from the patient's overall wait.

Case Study 14: Wait 2 System Delay – Patient Preference	Data Element	Reference Data
Evan, a 36-year-old male, was referred to Dr. Ruby, a Neurosurgeon, for a deep brain stimulation (DBS) implant to treat his Parkinson's Disease. During the consultation on November 3, 2011, Dr. Ruby recommended Evan have surgery and Evan agreed to be treated by Dr. Ruby. Dr. Ruby informed Evan that he is one of the few surgeons in the province who specializes in this type of surgery; therefore, Evan's wait will be quite long. Dr. Ruby suggests Evan have surgery with Dr. Diamond, a surgeon in another city who performs the same procedure, but who has shorter surgical wait times. Evan said he preferred to wait to have the surgery with Dr. Ruby, as he has built a relationship with him and feels very comfortable with his care. Dr. Ruby's first available time for surgery is March 1, 2012. Evan was scheduled to have his procedure on March 1, 2012, and his procedure was assigned a Priority Level 3.	Decision to Treat Date	November 3, 2011
	Is Wait 2 System Delay Applicable?	Yes
	Wait 2 System Delay Reason	Patient Preference
	Scheduled Procedure Date	March 1, 2012
	Procedure Date	March 1, 2012



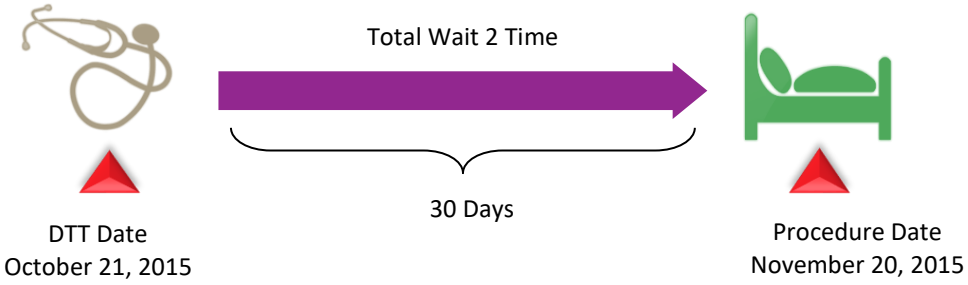
Wait 2 System Delay Reason: Patient Preference

System Delay not subtracted from wait time

Key Principle

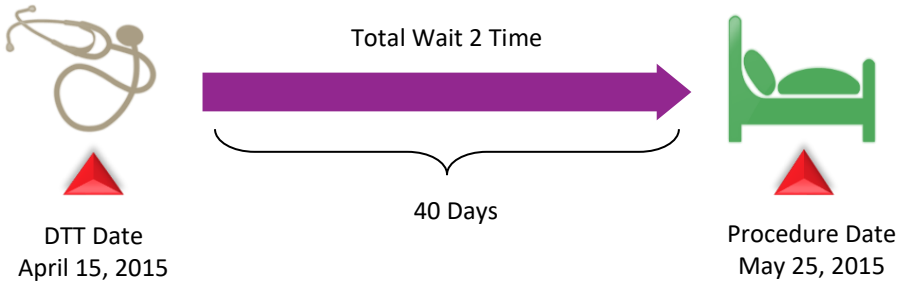
System delays are not subtracted from the patient's overall wait.

Case Study 15: Wait 2 – Low Probability of Cancer	Data Element	Reference Data
Betty is a 55-year-old female who was hospitalized due to ongoing headaches and seizures. During hospitalization, a CT scan revealed she has a convexity meningioma. Her Neurosurgeon, Dr. Rom, tells her these tumours are 90% benign in nature. On October 21, 2015, Dr. Rom recommends surgery. Betty agrees, and a decision to treat is made. The procedure is scheduled for November 20, 2015 and is assigned as a Priority Level 3.	Service Area	Neurosurgery
	Service Detail 1	Benign Tumour Surgery
	Service Detail 2	Meningioma
	Treating Healthcare Professional	Dr. Rom
	Priority Level	3
	Decision to Treat Date	October 21, 2015
	Scheduled Procedure Date	November 20, 2015
	Procedure Date	November 20, 2015



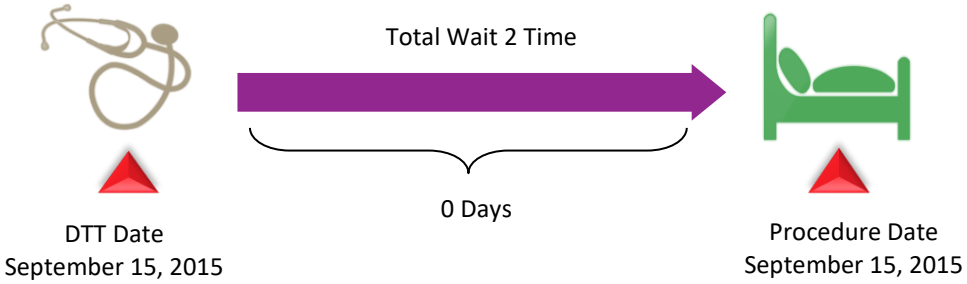
Key Principle
Adult cases with an extremely low probability of cancer should be captured under the benign service area rather than surgical oncology.

Case Study 16: Wait 2 – Fully Functional OR	Data Element	Reference Data
Maeve is a 70-year-old female with diabetes and a long-time smoker who suffers from peripheral vascular disease. After being admitted to the surgical unit, Vascular Surgeon, Dr. Sky, explains to Maeve that a below knee amputation on the right side is needed. A DTT was made on April 15, 2015, and Maeve is assigned as a Priority Level 3 case. Her procedure is scheduled within the next six weeks, on May 25, 2015, to Dr. Sky's assigned inpatient OR time.	Service Area	Vascular Surgery
	Service Detail 1	Amputation Surgery
	Service Detail 2	Below Knee
	Treating Healthcare Professional	Dr. Sky
	Priority Level	3
	Decision to Treat Date	April 15, 2015
	Scheduled Procedure Date	May 25, 2015
	Procedure Date	May 25, 2015



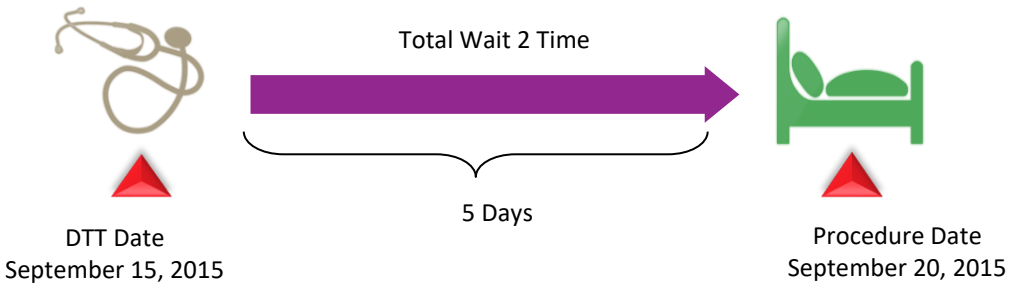
Key Principle
All procedures must be captured when completed in a fully-equipped OR.

Case Study 17: Wait 2 – Emergency Oncology Surgery	Data Element	Reference Data
Betty is an 85-year-old female who was brought to the ER with a three day history of constipation, vomiting and abdominal pain. She is unable to tolerate oral intake and requires IV narcotics for pain management. Betty is admitted to the hospital and the on-call General Surgeon, Dr. Carter, comes to examine her. On examination, she notices significant abdominal tenderness, dehydration and evidence on imaging of complete large bowel obstruction. Betty is diagnosed with Obstructing Sigmoid Colon Adenocarcinoma. Betty requires emergency surgery. The DTT for Betty is September 15, 2015. She consents for Dr. Carter to perform the emergency surgery on September 15, 2015 and the procedure is assigned as a Priority Level 1.	Service Area	Oncology
	Service Detail 1	Digestive System: Colorectal
	Service Detail 2	Treatment
	Treating Healthcare Professional	Dr. Carter
	Priority Level	1
	Decision to Treat Date	September 15, 2015
	Scheduled Procedure Date	September 15, 2015
	Procedure Date	September 15, 2015



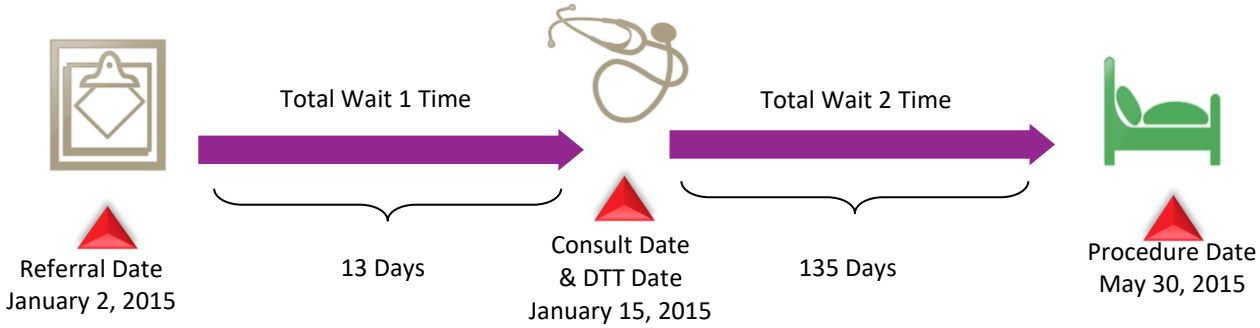
Key Principle
Priority Level 1 cases are immediate – emergency surgery is required within 24 hours.

Case Study 18: Wait 2 – Paediatric Surgery	Data Element	Reference Data
Justin is a 7-year-old male who was brought to the ER after sustaining a fall. His parents rushed him to the ER where he was diagnosed with maxillofacial fractures. Justin is admitted and the paediatrician refers him to a Paediatric Oral and Maxillofacial Surgeon, Dr. Russo, who explains to Justin's parents that he will need dental surgery to restore his mandible. The DTT for Justin was September 15, 2015. Justin's parents provide consent for Dr. Russo to perform the surgery on September 20, 2015 and the procedure is assigned as a Priority Level 2.	Service Area	Paediatric Oral & Maxillofacial Surgery and Dentistry
	Service Detail 1	Trauma
	Service Detail 2	N/A
	Treating Healthcare Professional	Dr. Russo
	Priority Level	2
	Decision to Treat Date	September 15, 2015
	Scheduled Procedure Date	September 20, 2015
	Procedure Date	September 20, 2015

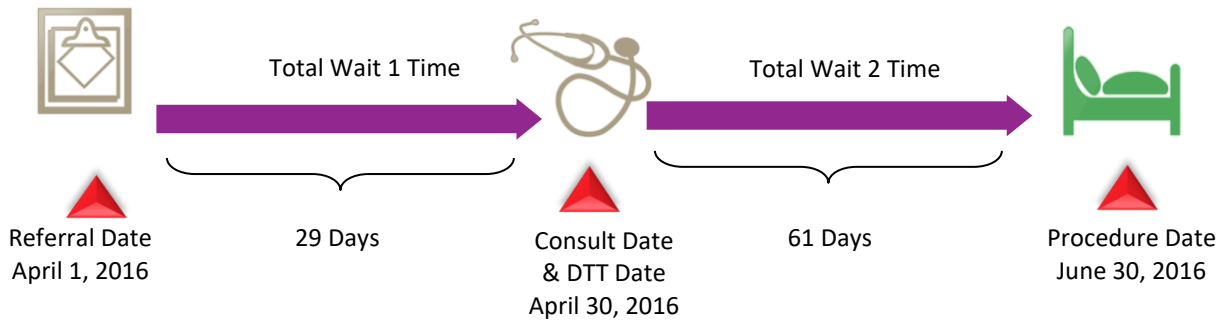


Key Principle
All procedures performed on paediatric patients should be captured under the appropriate paediatric service area.

Case Study 19: Wait 1 and Wait 2	Data Element	Reference Data
Talya is a 26-year-old female who has been experiencing diarrhea and abdominal cramps for the past few months. She was referred to Dr. Gladden, a General Surgeon, on January 2, 2011 by her primary care physician. During the January 15, 2011 consultation, Dr. Gladden recommended that Talya undergo a surgical procedure. Talya consents to the procedure, making her decision to be treated by Dr. Gladden on January 15, 2011. Since her symptoms are not severe in nature, Dr. Gladden assigns this case as a Priority Level 4. Talya is scheduled to have the procedure on May 30, 2011.	Referral Type	New Referral
	Referral Source	Other
	Referral Date	January 2, 2011
	Consult Date	January 15, 2011
	Service Area	General Surgery
	Service Detail 1	Anorectal Surgery
	Treating Healthcare Professional	Dr. Gladden
	Priority Level	4
	Decision to Treat Date	January 15, 2011
	Procedure Date	May 30, 2011

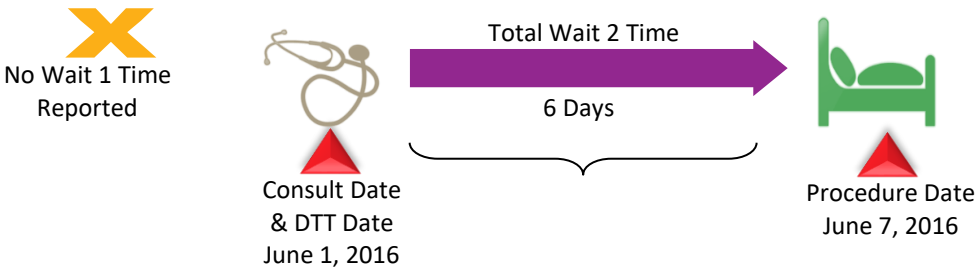


Case Study 20: Cancer Reconstructive Surgery	Data Element	Reference Data
Sid recently had surgery to treat stomach cancer. As a follow-up procedure, he needs reconstructive surgery on his abdominal wall. Sid's surgical oncologist referred him to Dr. Akbar, a Plastic Surgeon, on April 1, 2016. During the April 30, 2016 consultation, Dr. Akbar recommends Sid undergo the surgical reconstruction procedure and Sid agrees to be treated. The surgery takes place June 30, 2016.	Referral Type	ReReferral
	Referral Source	Other
	Referral Date	April 1, 2016
	Consult Date	April 30, 2016
	Service Area	Surgical Oncology
	Service Detail 1	Digestive System - Stomach
	Service Detail 2	Reconstruction
	Treating Healthcare Professional	Dr. Akbar
	Priority Level	Not Applicable
	Decision to Treat Date	April 30, 2016
	Procedure Date	June 30, 2016



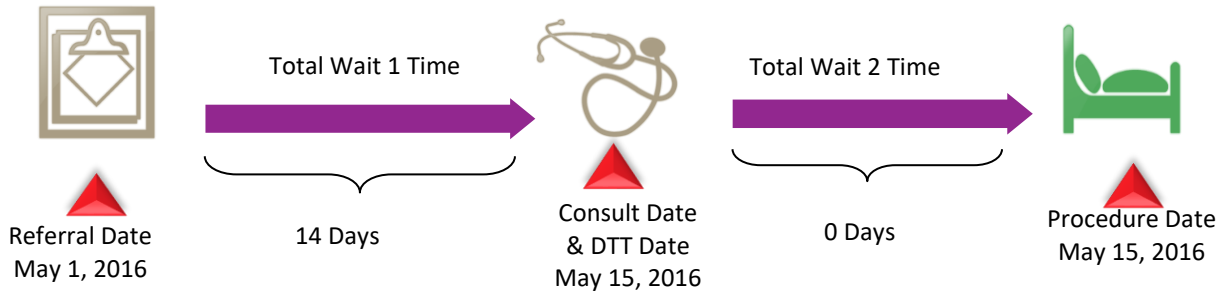
Key Principle
Cancer reconstruction procedures are reported using the Surgical Oncology SD2: Reconstruction.

Case Study 21: Cancer Palliative Surgery	Data Element	Reference Data
Ken has a near-obstructing rectal tumour that cannot be immediately excised. As a palliative measure, his current Surgical Oncologist, Dr. Prince suggests colonic stenting. He follows up with Ken on June 1, 2016 and they agree to proceed with the stenting surgery. Surgery takes place June 7, 2016.	Referral Type	No Referral/Follow-up (Existing Patient, Recurring Condition)
	Referral Source	Not Applicable
	Referral Date	Not Applicable
	Consult Date	Not Applicable
	Service Area	Surgical Oncology
	Service Detail 1	Digestive System - Colorectal
	Service Detail 2	Palliative
	Treating Healthcare Professional	Dr. Prince
	Priority Level	Not Applicable
	Decision to Treat Date	June 1, 2016
	Procedure Date	June 7, 2016



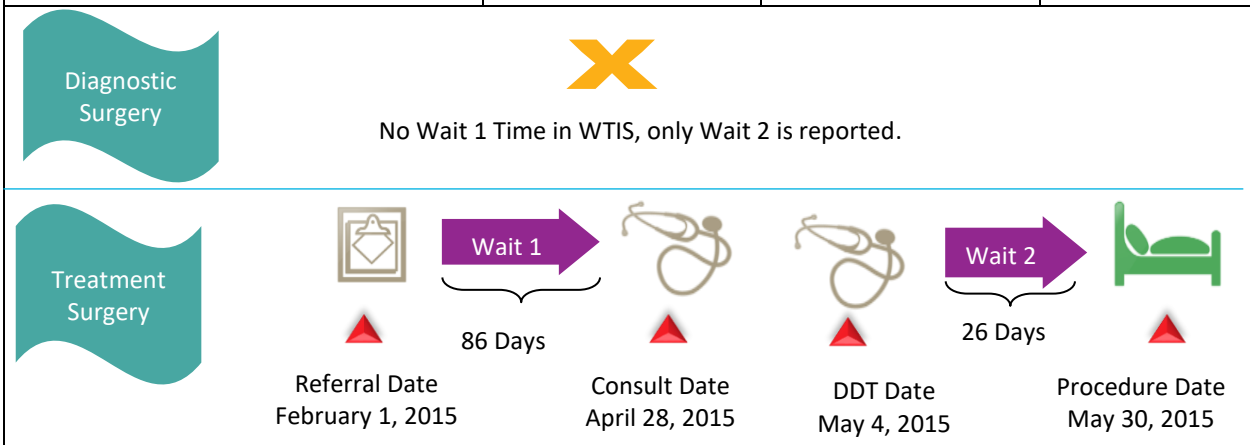
Key Principle
Cancer palliation surgeries are reported using the Surgical Oncology SD2: Palliative.

Case Study 22: Cancer Diagnostic Surgery	Data Element	Reference Data
Melanie's physician suspects she has breast cancer. A diagnostic biopsy is needed. Melanie is referred on May 1, 2016 for a consultation with Dr. Owen, a Surgical Oncologist. The consultation takes place May 15, 2016 and a decision to treat is made for surgical biopsy procedure. The procedure also takes place on the same day. The biopsy was positive for cancer and the patient was referred to a surgical oncologist to discuss treatment.	Referral Type	New Referral
	Referral Source	Other
	Referral Date	May 1, 2016
	Consult Date	May 15, 2016
	Service Area	Surgical Oncology
	Service Detail 1	Breast
	Service Detail 2	Diagnostic
	Treating Healthcare Professional	Dr. Owen
	Priority Level	Not Applicable
	Decision to Treat Date	May 15, 2016
	Procedure Date	May 15, 2016



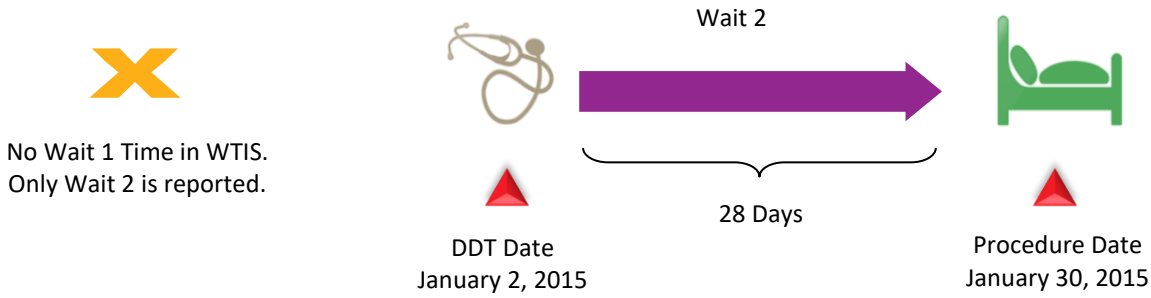
Key Principle
Cancer diagnostic surgeries are reported using the Surgical Oncology SD2: Diagnostic.

Case Study 23: Diagnostic Surgery and Treatment Surgery with the Same Clinician	Data Element	First Waitlist Entry	Second Waitlist Entry
On February 1, 2015, Gordon is referred to Dr. Jones for a diagnostic procedure. The patient meets Dr. Jones for the first time on April 28, and the diagnostic procedure takes place in a fully functional OR. Dr. Jones arranges a follow-up with Gordon to discuss results, and a decision to treat for surgery is made on May 4, 2015 for a positive diagnosis. A surgical treatment takes place May 30, 2015.	WTIS Procedure	Surgical Oncology-Diagnostic	Surgical Oncology-Treatment
	Referral Type	No Referral/Follow-Up	New Referral
	Referral Date	Not Applicable	February 1, 2015
	Consult Date	Not Applicable	April 28, 2015
	Decision to Treat	April 28, 2015	May 4, 2015
	Procedure Date	April 28, 2015	May 30, 2015



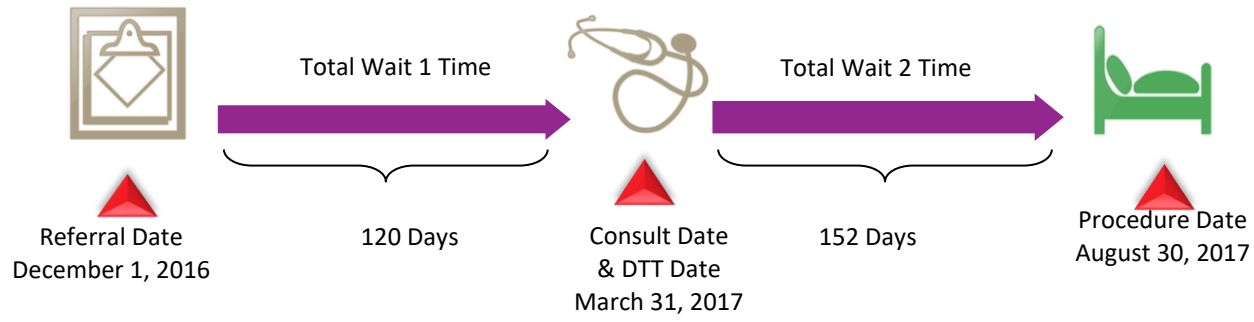
Key Principle
Report the patient's Wait 1 data in the waitlist entry for the surgical oncology treatment case.

Case Study 24: Wait 1 and Cancer Screening	Data Element	Reference Data
Kirk is referred to Dr. Bones for a colonoscopy cancer screening procedure. The procedure takes place and Dr. Bones arranges a follow-up with Kirk to discuss the results. A decision to treat for surgery is made on January 2, 2015 and surgery takes place January 30, 2015. Kirk has no Wait 1 for surgery because he was referred for screening and no subsequent referral was required for a surgical consultation.	Referral Type	No Referral/Follow-Up
	No Referral/Follow-Up Reason	Existing Patient – New Condition
	Decision to Treat	January 2, 2015
	Procedure Date	January 30, 2015

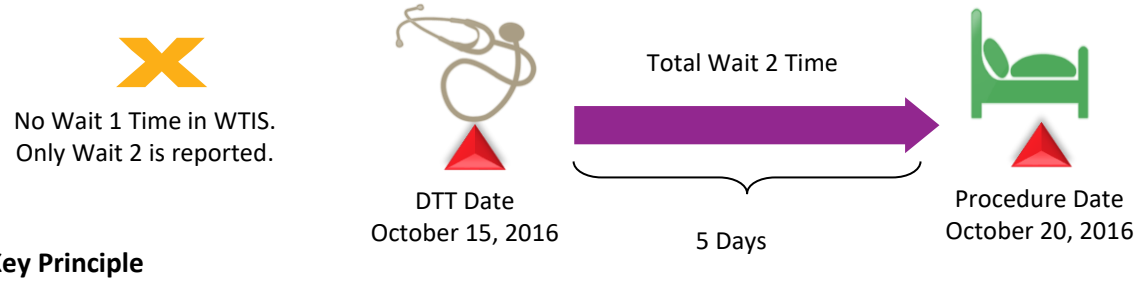


Key Principle
Wait 1 is not reported for cancer screening patients because wait times for colonoscopies are reported by the Colon Cancer Check program at Ontario Health (Cancer Care Ontario).

Case Study 25: Prophylactic Surgery	Data Element	Reference Data
Rose has elected to have prophylactic breast removal due to her medical and familial history. Her primary care physician refers her on December 1, 2016 to Dr. George for a surgical consultation. The consultation takes place March 31, 2017 and a decision to treat for surgery is made on the same day. The surgery takes place on August 30, 2017.	Referral Type	New Referral
	Referral Source	Other
	Referral Date	December 1, 2016
	Consult Date	March 31, 2017
	Service Area	General Surgery
	Service Detail 1	Benign Breast Disease
	Treating Healthcare Professional	Dr. George
	Priority Level	4
	Decision to Treat Date	March 31, 2017
	Procedure Date	August 30, 2017



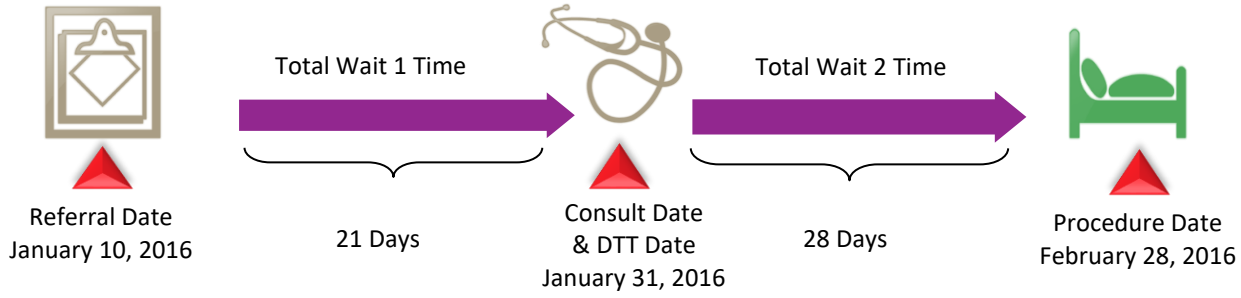
Case Study 26: Cancer Preparation Surgery	Data Element	Reference Data
Grant is scheduled to have stomach cancer surgery. Prior to cancer surgery, he meets with his current Surgical Oncologist Dr. Lee on October 15, 2016. They both agree a surgically inserted feeding tube to bypass the esophagus is needed prior to cancer surgery. Surgery to insert the feeding tube takes place on October 20, 2016.	Referral Type	No Referral/Follow-Up
	Referral Source	Existing Patient – Recurring Condition
	Referral Date	Not Applicable
	Consult Date	Not Applicable
	Service Area	General Surgery
	Service Detail 1	Digestive System
	Service Detail 2	Stomach and Duodenum
	Treating Healthcare Professional	Dr. Lee
	Priority Level	2
	Decision to Treat Date	October 15, 2016
	Procedure Date	October 20, 2016



Key Principle

Cancer preparation procedures are not considered surgical oncology procedures and they should be reported under the appropriate benign surgical service area.

Case Study 27: Combination Procedures that are Clinically Related	Data Element	Reference Data
Renata was referred to Dr. Sheldon on January 10, 2016 to discuss treatment for a cancerous brain tumour. The consultation took place on January 31 2016. At the consultation, Renata agrees with Dr. Sheldon's decision to treat to remove the tumour through surgery, which would be followed by surgery to revise the skin flap over the tumour site. The second surgery would be conducted by a Plastic Surgeon. The combination procedures takes place on February 28 2016.	Referral Type	New Referral
	Referral Source	Other
	Referral Date	January 10, 2016
	Consult Date	January 31, 2016
	Service Area	Surgical Oncology
	Service Detail 1	Primary Nervous System
	Treating Healthcare Professional	Dr. Sheldon
	Priority Level	3
	Decision to Treat Date	January 31, 2016
	Procedure Date	February 28, 2016

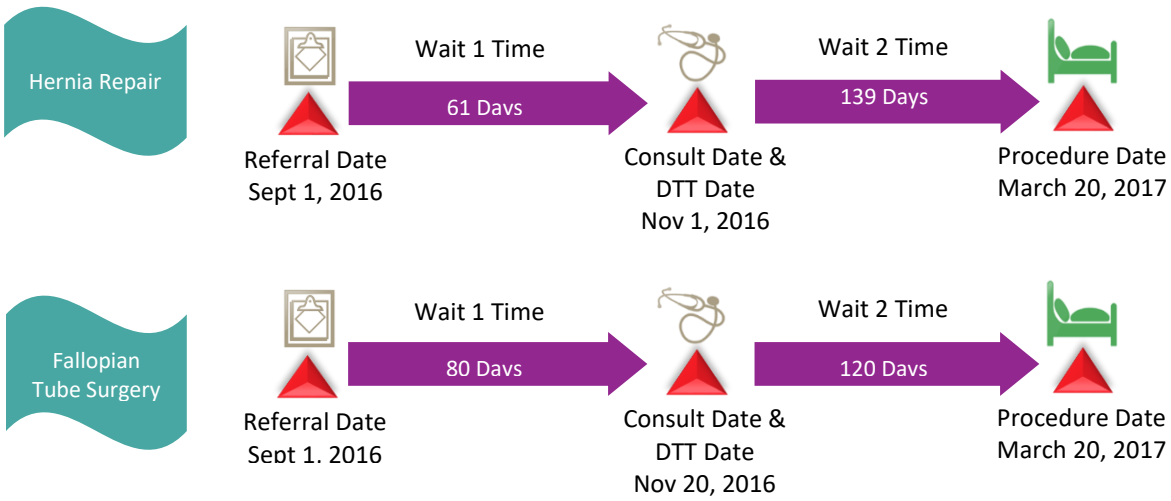


Key Principles

For combination surgical procedures, only one waitlist entry should be created for the primary procedure. When multiple clinicians are involved in the surgery, the waitlist should be entered under the leading clinician for the primary procedure.

Two surgical procedures are clinically related if they have a treatment, pathological or anatomical relationship wherein the optimal operative intervention requires the two procedures to take place at the same time.

Case Study 28: Clinically Unrelated Concurrent Procedures	Data Element	First Waitlist Entry	Second Waitlist Entry
Bessie was referred by her primary care physician to Dr. Brown on September 1, 2016 for a surgical consult for hernia repair. The consult takes place on November 1, 2016 and Bessie and Dr. Brown make a decision to treat. Bessie was also referred by her primary care physician on September 1, 2016 to Dr. Serta for a tubal ligation consultation. The consult takes place on November 20, 2016 and Bessie and Dr. Serta make a decision to treat. Bessie requests the two surgeries take place on the same day so that she can have all her surgical procedures take place in one hospital visit, and the two procedures take place on March 20, 2017.	Referral Type	New Referral	New Referral
	Referral Source	Other	Other
	Referral Date	September 1, 2016	September 1, 2016
	Consult Date	November 1, 2016	November 20, 2016
	Service Area	General Surgery	Gynaecology Surgery
	Service Detail 1	Hernia Repair	Fallopian Tube Surgery
	Treating Healthcare Professional	Dr. Brown	Dr. Serta
	Priority Level	4	4
	Decision to Treat Date	November 1, 2016	November 20, 2016
	Procedure Date	March 20, 2017	March 20, 2017



Key Principles

When two clinically unrelated surgical procedures are performed, as either an administrative convenience and/or to avoid multiple anaesthetics and/or operative episodes for the patient, this is not considered a combination procedure and the two procedures would each have a separate waitlist entry.

Two surgical procedures are clinically related if they have a treatment, pathological or anatomical relationship wherein the optimal operative intervention requires the two procedures to take place at the same time.

Appendix B: Data Elements and System Labels

Demographic Data Elements	Definition
First Name	The patient's given name.
Middle Name	The patient's middle name or further given names.
Last Name	The patient's surname.
Date of Birth	The patient's date of birth (yyyy-mm-dd).
Site	The healthcare site where the patient receives care.
Facility	The healthcare facility where the patient is registered and where the procedure took place.
LHIN	Local entities designed to plan, integrate and fund local health services.
Treating Healthcare Professional	The healthcare professional name and identifier code for the physician who oversees the procedure.
Health Card Number (HCN)	The numeric portion of the patient's health insurance card number assigned by the provincial government.
Health Card Number Version	The two-character alphanumeric code which uniquely identifies a health card version.
Issuing Authority	The name of the province that creates/issues the patient's health card.
Sex/Gender	Patient gender code.
Address	Patient street address.
Address Type	Patient address type (e.g. home [H], mailing [M], temporary [T], current [C]).
City	City of patient residence.
Province/State	Province or state of patient's residence.
Country	Country code of patient's residence.
Postal/Zip Code	Patients' postal/zip code of their home address. A postal/zip code is a series of letters and/or digits appended to a postal address for the purpose of sorting mail.
Phone Number	The patient's phone number.
Phone Number Type	The patient's phone number type (e.g., home or business).
Medical Record Number (MRN)	The Medical Record Number is a unique identifier used to identify an individual and his or her medical record/information.

Demographic Data Elements	Definition
Order Number	The unique number, which identifies and tracks the order for diagnosis imaging.
Case Number	The case number is a hospital identifier that must be unique across all sites within your facility and all areas of care. It will be used to identify the waitlist entry during its lifespan.
Waitlist Entry ID	The unique identifier for the waitlist entry.
Waitlist Entry Status	Reflects whether the patient is still waiting or has had the procedure. It refers to the completeness of the record. O = open – currently waiting. C = closed – procedure completed.

Table 13: Demographic Data Elements

Wait 1 Data Element and System Labels	Definition
Wait 1	The time that the patient waits for a first consultation with a clinician. It is measured from the time the referral is received to the date the first consultation with a clinician occurs.
Wait 1 (Days)	The total number of days the patient waited for the first consultation with a clinician. It is measured from the date the referral is received to the date of the first consultation with the clinician.
Wait 1 Priority Level	The level of priority for the consultation used to identify similar patients in need of care. Priority levels are defined as the following: Priority Level 1 – immediate Priority Level 2 – urgent Priority Level 3 – semi-urgent Priority Level 4 – elective (less urgent for cancer surgery)
Wait 1 Access Target (Days)	The maximum recommended wait time in days for the associated priority level as recommended by clinical expert panels.
Referral Date	The date (yyyy-mm-dd) a request for a clinician consultation is received.
Referral Source	The origin of a patient's referral, for example, the referral was received from a DAP/Unit, a Central Intake, or another referral source, such as: a primary care physician.

Wait 1 Data Element and System Labels	Definition
Referral Source Options	**DAP/Unit:** The DAP/Unit (DAP) coordinates the patient journey from referral for suspicion of cancer to a definitive diagnosis. They include the full spectrum of multidisciplinary diagnostic testing in an environment focused on the patient. DAP cannot be selected as a Referral Source unless Service Area is Surgical Oncology and SD 1 is Colorectal, Prostate or Lung. **Central Intake:** A model of care that utilizes a single process to facilitate patient access to specialized care across multiple hospitals or within the same hospital. **Other:** Includes all other referral sources other than DAP/Unit and Central Intake. This could include: a primary care physician, another specialist, the ER, a clinic, the inpatient unit at hospital, or referral from another Healthcare Professional other than a physician.
Referral Type	The type of transfer of care for a patient from one clinician to another clinician for a first surgical consultation. For patients where no referral information is available use No Referral/Follow-Up.
Referral Type Options	• **New Referral**: A referral for a patient who is seeing a clinician for the first time, or an existing patient with a new referral to the same clinician. • **ReReferral**: A referral for a patient who has already seen a clinician or is seeking a second opinion (which includes secondary referrals for complex/staged procedures). • **No Referral/Follow Up:** Returning patient who is having ongoing multiple surgical interventions with the same surgeon. • **Self-referrals:** Returning patient who has recurring consults or follow-up visits and no Wait 1 data is available.

Wait 1 Data Element and System Labels	Definition
No Referral / Follow Up Reasons	• **Existing Patient (New Condition)**: A patient who returns to see the clinician with a new condition but has no new referral. This could include a patient who has an unexpected surgery without a referral for consultation or may include patients where the clinician identifies a new condition during follow-up visits for an existing condition. • **Existing Patient (Recurring Condition)**: A previous surgically-treated patient who returns for ongoing care for a recurring condition. This could include an existing patient that is followed for a number of years before a DTT for surgery is made and Wait 1 data is unavailable. • **New Patient (No Referral)**: A new patient who sees the clinician without a referral. This could include patients who self-refer for a consultation.
Consult Date	The date (yyyy-mm-dd) the patient had their first consult with the clinician.
DARC (DARC)	Periods of time between the referral and consult date when the patient is unavailable for a first consultation due to patient-related reasons. The time will be subtracted from the overall Wait 1. The patient-related reasons do not include system-related delays such as surgeon unavailability, emergency closures or reduced clinic hours.

Wait 1 Data Element and System Labels	Definition
DARC (DARC) Reasons	**Developmentally Appropriate Wait**: The clinician determines that a consultation is required, but that it cannot occur until the paediatric patient has reached a certain stage in development. This DARC reason applies only to pediatric cases.
	Inability to Contact the Patient: The clinician's office has made a reasonable effort to contact the patient in order to schedule or confirm the date and time for the first consultation but has not been able to do so.
	Change in Medical Status: The patient's medical status has changed such that the first consultation cannot be performed until the patient's condition stabilizes.
	Missed Consultation: The patient is not present for the first consultation at the scheduled date and time and as a result the consultation must be rescheduled. Patient does not inform the office that they will not be able to attend their appointment. This will only be captured as a 1 day delay in the WTIS.
	Patient Chooses to Defer: The patient is unavailable for the first consultation due to personal reasons (such as a vacation or a death in the family), personal preferences for the date and time of the consultation, or weather reasons (such as road and airport closures).
	Pre-Defined Follow-Up Interval: The clinician determines that the first consultation is required at a clinically defined point in the future. This could include waiting for medical clearance by an internist or accommodating the coordination of multiple services.
DARC From Date	The beginning date (yyyy-mm-dd) of a period of time when the patient is unavailable for a first consultation due to patient-related reasons.
DARC To Date	The end date (yyyy-mm-dd) of a period of time when the patient is unavailable for a first consultation due to patient-related reasons.
Wait 1 System Delay	Healthcare system delays that are non-patient related and impact the patient's wait time for a first consultation. The delays may include clinician unavailability, limited clinic time, or lack of referral information. The delays will not be subtracted from the overall Wait 1.

Wait 1 Data Element and System Labels	Definition
Wait 1 System Delay Reasons	**Emergency Closures**: The first consultation is delayed due to unforeseen unavailability of healthcare resources. This could include clinic closures due to infectious outbreaks, extreme weather or other emergency situations.
	Lack of Hospital/Clinic Resources: The first consultation is delayed due to unavailability of non-surgeon staff or reductions to clinic operating hours.
	Patient Preference: The first consultation is delayed due to the patient's choice to remain on the waitlist of a particular clinician or at a particular location despite being offered the option of an earlier consultation with another surgeon.
	Prerequisites Not Completed: The first consultation is delayed due to missing or incomplete referral information. This could include incomplete labs or tests that delay the consultation.
	Rescheduled Due to Higher Priority Case: The first consultation is delayed to accommodate a higher priority patient.
	Surgeon Unavailability: The first consultation is delayed due to surgeon unavailability. This could include absence due to vacation or lack of available appointments in their schedule.

Table 14: Wait 1 Data Elements and System Labels

Wait 2 Data Element and System Labels	Definition
Wait 2	The time that the patient waits for surgical or diagnostic imaging procedures. For surgical procedures, Wait 2 is measured from the DTT (DTT) date to the date the procedure is performed.
Wait 2 (Days)	Total number of days the patient has been waiting for the procedure (if the patient has not yet received the procedure), or the total number of days the patient waited for the procedure.
Service Area	A high-level category of the defined procedures.
SD 1	The sub-category of the service area.
SD 2	A further breakdown for SD 1 (e.g., breakdowns of cancer surgery are: diagnostic, treatment, palliative or reconstructive).
Wait 2 Priority Level	The level of priority for the procedure used to identify similar patients in need of care. Priority levels are defined as the following: Priority Level 1 – immediate Priority Level 2 – urgent Priority Level 3 – semi-urgent Priority Level 4 – elective (less urgent for cancer surgery)
Patient Type	The type of patient receiving the procedure
Patient Type Options	**Inpatient**: A patient who is admitted prior to procedure in a fully-equipped OR, and will remain an inpatient after procedure. This term also applies to a patient arriving the day of procedure, who will be admitted after the procedure. **Outpatient**: A patient arriving on the day of the scheduled procedure and departing the day of procedure.
Wait 2 Access Target (Days)	The maximum recommended wait time in days for the associated priority level as recommended by clinical expert panels. **This applies to Wait 2 procedures only.**
Variance (Days)	The difference, either positive or negative, between the current wait time of a patient and the defined provincial access target based on assigned priority level.
Responsibility for Payment	Identifies the primary group responsible for payment of service(s) rendered.

Wait 2 Data Element and System Labels	Definition
Responsibility for Payment Options	**Provincial Government/OHIP**: Payment is made by the Ontario Health Insurance Program. **Private Coverage**: Payment is made by patients paying for services out of pocket or through private insurance coverage. **Other:** Payment is made by federal government programs including: Department of Veterans Affairs Canada (VAC), First Nations and Inuit Health Branch, RCMP Department of National Defense, penitentiary inmates or immigration. Payment is made by a worker's service insurance board (e.g., WSIB or WCB etc.), other province or territory insurance plans in Canada (other than Ontario)
DTT Date	The date (yyyy-mm-dd) the clinician decides that a surgical procedure is required, and the patient agrees to undergo the procedure and be placed on a waiting list.
Procedure Date	The date (yyyy-mm-dd) the actual procedure was performed.
Procedure No Longer Required	A predefined reason why the procedure is not required. CP = Cancelled by Patient ER = Data Entry Error IC = Improved Medical Condition MS = No Longer Medically Stable PD = Patient Death PC = Procedure Completed Elsewhere
Scheduled Procedure Date	The date (yyyy-mm-dd) which the procedure is scheduled to be performed.
Reschedule Procedure Date	The date (yyyy-mm-dd) which the procedure has been rescheduled.
Reschedule Reason	Reason for rescheduling already scheduled surgery procedure. LB = Lack of bed availability LS = Lack of available staff MC = Medical complications/reasons ME = Medications MT = Medical specialty consult or tests OT = Other RP = Rescheduled due to higher priority case TD = Transfer delays

Wait 2 Data Element and System Labels	Definition
DART (DART)	Periods of time between the DTT date and the Actual Procedure date when the patient is unavailable for the procedure due to patient-related reasons. The period of time will be subtracted from the overall Wait 2. The patient-related reasons do not include system-related delays such as clinician unavailability or OR closures.
DART (DART) Reason	**Developmentally Appropriate Wait**: The clinician has made the DTT but determines that the procedure cannot occur until the paediatric patient has reached a certain stage in development. This DART reason applies only to pediatric cases.
	Inability to Contact the Patient: The clinician's office has made a reasonable effort to contact the patient in order to schedule or confirm the date and time for the procedure but has not been able to do so.
	Change in Medical Status: The patient's medical status has changed such that the procedure cannot be performed until the patient's condition improves or deteriorates further.
	Missed Surgery/Procedure: The patient is not present for their procedure at the scheduled date and time and, as a result, the procedure must be rescheduled. Patient does not inform the office that they will not be able to attend their scheduled procedure. This will only be captured as a 1 day delay in the WTIS.
	Neo-Adjuvant Chemotherapy: The patient requires chemotherapy before the procedure.
	Neo-Adjuvant Radiation Therapy: The patient requires radiation therapy before the procedure.
	Other Surgical Procedure: The clinician has made the DTT but the patient must undergo another surgical procedure prior to this procedure.
	Patient Chooses to Defer: The patient is unavailable for the procedure due to personal reasons (such as a vacation or a death in the family), personal preferences for the date and time of the procedure, or weather reasons (such as road and airport closures).
	Pre-Defined Follow-Up Interval: The clinician has made the DTT but determines that the procedure is required at a clinically defined point in the future. This could include a follow-up in three months or a cancer re-check in one year.
DART From Date	The beginning date (yyyy-mm-dd) of a period of time when the patient is unavailable for the procedure due to patient-related reasons.

Wait 2 Data Element and System Labels	Definition
DART To Date	The end date (yyyy-mm-dd) of a period of time when the patient is unavailable for the procedure due to patient-related reasons.
Wait 2 System Delays	Healthcare system delays that are non-patient-related and impact the patient's wait time for a procedure. The delays may include clinician unavailability, limited OR time or bed unavailability. The delays will not be subtracted from the overall Wait 2.
Wait 2 System Delay Reasons	**Emergency Closures**: The procedure is delayed due to unforeseen unavailability of healthcare resources. This could include OR or radiology suite closures due to infectious outbreaks, extreme weather or other emergency situations.
	Lack of Hospital Resources: The procedure is delayed due to the unavailability of non-surgeon staff, beds or OR time.
	Patient Preference: The procedure is delayed due to the patient's choice to remain on the waitlist of a particular clinician or at a particular location despite being offered the option of an earlier procedure date.
	Prerequisites Not Completed: The procedure is delayed due to missing or incomplete patient information. This could include incomplete labs or tests that are required prior to the procedure.
	Rescheduled Due to Higher Priority Case: The procedure is delayed to accommodate a higher priority patient.
	Surgeon Unavailability: The procedure is delayed due to surgeon unavailability. This could include absence due to vacation or lack of available appointments in their schedule.
90th Percentile Wait Time	This is the point at which 90 percent of the patients received their treatment and the other 10 percent waited longer. For example, if a 90 percentile wait time is 58 days, this means that 90 percent or 9 out of 10 of the patients waited 58 days or less and the other 10 percent waited more than 58 days.
Median Wait Time	This is the point at which half the patients have had their treatment and the other half are still waiting. For example, if a median wait time is 26 days, this means that half of the patients waited 26 days or less and half waited more than 26 days.

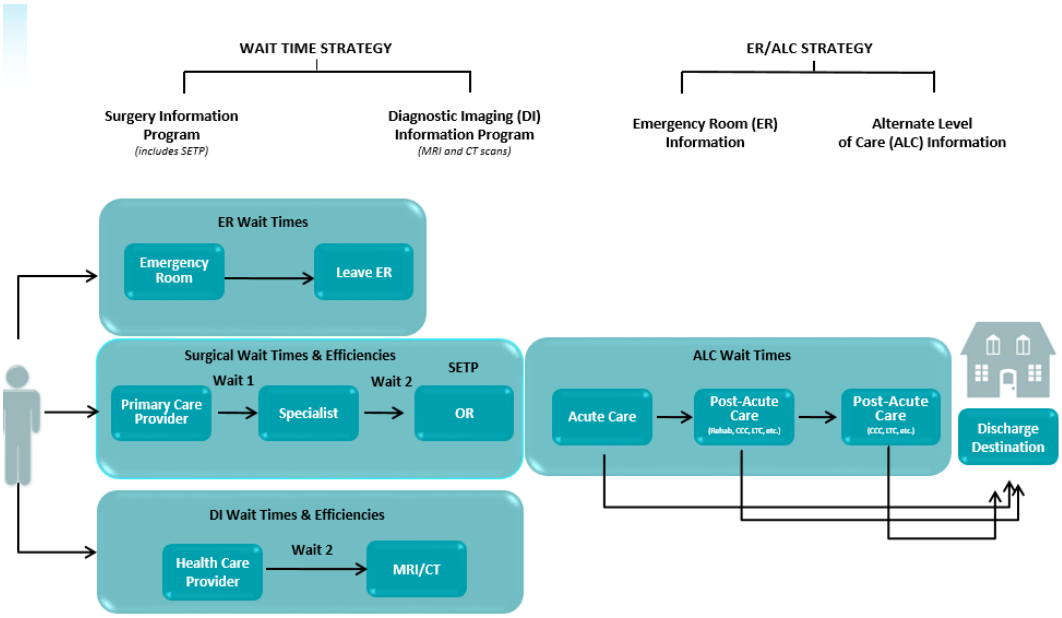
Table 15: Wait 2 System Labels and Data Elements

Appendix C: History of Ontario's Wait Time Strategy (WTS)

On November 17, 2004, the Ministry of Health and Long-Term Care announced Ontario's WTS aimed at improving access to healthcare services for Ontarians. The strategy was developed in response to increased budgetary constraints and an aging population, resulting in a growing demand for surgery and diagnostic imaging scans that would quickly become unsustainable. Key objectives of the WTS were to:

- Empower patients and demonstrate accountability to the public
- Increase health system capacity with more equitable and efficient use of resources
- Inform the ministry and LHINs on wait time trends and potential pressure areas
- Encourage hospitals to develop effective models, practices, and strategies to overcome clinically inappropriate waiting times
- Create hospital boards and management accountability for managing access
- Develop tools that provide a consistent method of assigning appropriate clinical urgency of patients, determined by expert panels
- Track, monitor and improve performance through a single provincial WTIS with standardized data and targets
- Through feedback from clinical experts, provide timely, accurate, province-wide information that provides public reporting on how many Ontarians are waiting for a selected healthcare service, how long they have waited, and their relative urgency for service

The WTS also focuses on diagnostic imaging and surgical efficiency, and it complemented the ER/ALC Strategy as illustrated below.



Patients First: Action Plan

The WTS continued to evolve when the Minister of Health refreshed the vision for access to care with the Patients First: Action Plan in 2015. This is the next phase of Ontario's plan for continuously improving Ontario's health system, building on the progress that has been made in access to care for Ontario. It commits to putting people and patients at the center of the system by focusing on patients' needs first. A major component of this plan is improving access by providing faster access to the right care. To learn more about the ministry's strategy, please visit http://www.health.gov.on.ca/en/ms/ecfa/healthy_changes.

SIP (Surgical Information Program)

Cancer Care Ontario (now a part of Ontario Health) established a program and built the Wait Time Information System (WTIS) in 2006 to capture wait times in five key priority areas: cancer surgery, cardiac procedures, cataract surgery, hip and knee replacement surgery, and diagnostic imaging. The strategy initially focused on Wait 2, the time between a specialist's and patient's DTT, and the provision of treatment.

Cancer Care Ontario developed a network of surgeons to inform the requirements for building the WTIS and eventually developed a program known as Access to Care (ATC).

To manage surgical wait time initiatives, the SIP was created as a line of business under Access to Care.

WTIS History

The WTIS launched in 2006 with the five priority areas mentioned above. It then expanded between 2007 and 2009 to report on 12 adult and 10 paediatric surgical service areas. Table 16 provides a summary.

Timeline	WTIS Expansions	
2006	WTIS launched to collect Wait 2 data for Oncology Surgery, Cataract Surgery, Hip & Knee Replacement Surgery and MRI/CT Scans. Wait 2 data capture also included patient delay reasons to add more context to patients' wait times Patients Delays (DARCs and DARTs)	
2007-2009	WTIS expanded to collect Wait 2 data for more surgical areas:	
	• General Surgery • Gynaecology Surgery • Neurosurgery • All Ophthalmology Surgery • Oral/Maxillofacial Surgery & Dentistry • Oncology Surgery	• All Orthopaedic Surgery • Otolaryngology Surgery • Plastic and Reconstructive Surgery • Thoracic Surgery • Urology Surgery • Vascular Surgery
2009	WTIS expanded to collect Wait 2 data for Paediatric Surgery	
	• Paediatric Cardiovascular Surgery • Paediatric General Surgery • Paediatric Gynaecology Surgery • Paediatric Neurosurgery • Paediatric Ophthalmology Surgery • Paediatric Urology Surgery	• Paediatric Oral/Maxillofacial Surgery & Dentistry • Paediatric Orthopaedic Surgery • Paediatric Otolaryngology Surgery • Paediatric Plastic and Reconstructive Surgery
2012	WTIS expanded to collect information on System Delays to help demonstrate the impact of system-related barriers to care.	
2012	WTIS expanded to collect Wait 1 data. For more information on Wait 1 reporting, the time a patient waits for their first consultation with a surgeon see the Referral Type and Referral Source sections or Appendix A: Wait 1 and Wait 2 Case Studies.	
2016	The latest WTIS enhancements in 2016 enabled surgeons to report on Wait 1 Priority Level for patients, supporting timely consultation for patients in similar need of care.	

Table 16: WTIS Evolution

Adult Service Areas	Paediatric Service Areas
General Surgery	Paediatric Cardiovascular Surgery
Gynaecology Surgery	Paediatric General Surgery
Neurosurgery	Paediatric Gynaecology Surgery
Oncology Surgery	Paediatric Neurosurgery
Ophthalmology Surgery	Paediatric Ophthalmology Surgery
Oral/Maxillofacial Surgery & Dentistry	Paediatric Oral/Maxillofacial Surgery & Dentistry
Orthopaedic Surgery	Paediatric Orthopaedic Surgery
Otolaryngology Surgery	Paediatric Otolaryngology Surgery
Plastic and Reconstructive Surgery	Paediatric Plastic and Reconstructive Surgery
Thoracic Surgery	Paediatric Urology Surgery
Urology Surgery	
Vascular Surgery	

Table 17: WTIS Surgical Service Areas

Ontario Health measures, manages, and reports on surgical wait times for approximately 650,000 surgeries each year in over 200 procedure categories from over 3,200 clinicians at 91 facilities. In the WTIS we currently capture 122 total data fields (includes reference data) and 58 data elements.

- 4 reference data fields + 26 data elements = 30 patient demographic info data fields
- 25 reference data fields + 12 data elements = 37 wait 1 data fields
- 35 reference data fields + 20 data elements = 55 wait 2 data fields

Through this data, a comprehensive picture of performance at the provincial, regional, hospital, and clinician-level is available in near real-time. Reports are generated for multiple stakeholders, including monthly public reporting of provincial and hospital level performance.

CCI Code and WTIS Procedure Mapping

Since the WTIS began with 5 priority procedures (as mentioned above) and then expanded to report on different surgical Service Areas, specific procedures were not the focus but grew organically as the WTIS evolved over time. As a result, there exists overlap between CCI codes and WTIS procedures. That is, a CCI code can map to more than one Service Detail 1 or Service Detail 2 category within or between different surgical Service Areas. This overlap exists due to 2 main reasons:

1. The guiding principles behind and the format and structure of the CCI codes
2. The development and structure of the WTIS

The CCI code definition of interventions are generic. The first 5 characters of the CCI code describes the intervention and any characters after that are qualifiers that describe *how* the intervention was performed.

In the WTIS, surgical procedure categories (and sub-categories) were developed specific to different surgical Service Areas. These procedure categories (Service Detail 1 and Service Detail 2) are buckets under which a number of procedures can be grouped.

For example, 1.KY.76^^ (the CCI code for “bypass, artery with vein”) describes the intervention. Any characters after this would only describe how this intervention was done (i.e. using a shunt or a particular type of graft). However, in the WTIS, within the Vascular Surgery Service Area, this intervention can be performed as part of an Arterial Bypass Surgery (SD 1), a Non-Bypass Arterial Surgery (SD 1) or an Arteriovenous Surgery for Dialysis (SD 1). Similarly, this intervention can also be performed under the General Surgery Service Area (SD 1 Skin and Structures Surgery) and the Thoracic Surgery Service Area (SD 1 Benign Mediastinal Surgery). Hence, a particular CCI code can map to several different SD 1 or SD 2 categories within or between different surgical Service Areas. The overlap is expected.

Value of Collecting Wait Time Data

The capture of wait time information provides access to timely and standardized data that can enable significant performance improvement at provincial, LHIN, hospital and surgeon levels.

The WTIS enables clinicians and their office staff to capture data electronically through one system which allows time saving, improvement of data accuracy and standardization as well as active management of waitlists. With near real-time data, facilities and clinicians can ensure patients with the highest priority are cared for first. Moreover, public reporting of the data allows patients to explore their healthcare options.

The collection and measurement of wait time data provides a more complete picture of the patient journey to help improve processes for access to healthcare for surgical patients in Ontario. Additional benefits of the WTIS include:

- Increases transparency to hospital administration to identify problem areas and allocate surgical resources accordingly
- Provides an informed basis for discussions among clinicians and administrators regarding access to care issues, ensuring a consistent method for deciding who needs care most
- Provides access to information for patients and providers on the shortest available wait by hospital
- Provides the public with a standardized mechanism to hold the government accountable on their promise to reduce wait times
- Makes high quality wait time data for all service areas available on the ministry's public website, to assist patients in making informed decisions about their care

Appendix D: Funding and Wait Time Reporting

Ministry Direction

The Ministry issues a Ministry LHIN Accountability Agreement (MLAA) to each LHIN every year to provide funding allocations for surgical procedures. Within the contract, LHINs agree their hospitals will report and use data in the WTIS to monitor their wait time performance. The LHINs then provide each of their hospitals with an accountability agreement for surgical funding that mirrors these wait time requirements. When hospitals accept the funding, they agree to:

- Appoint a WTIS Surgery Coordinator to act as a single point of contact to support the project and operational requirements
- Report accurate Wait 1 and Wait 2 data for all service areas available in the WTIS
- Participate in all aspects of future ATC implementation and/or operational initiatives
- Maximize the use of the data that is captured and reported
- Work towards reducing wait times and improving efficiencies by continuously managing its wait lists and optimizing surgical efficiencies for services reported to the WTIS
- Participate fully in all aspects of data compliance and DQ processes
- Use appropriate flags in the WTIS to reflect accurately the patient's wait and provide additional context for the waitlist entry, such as DARCs, DARTs and System Delays
- Adhere/align to ATC's data resubmission policy as required

Volume Reconciliation

Please note: The WTIS should not be used to reconcile volumes for funding purposes. There are several reasons for this:

1. The WTIS captures data for a broad yet select group of procedures.
2. The WTIS does not require submission of non-cancer Priority 1 procedures.
3. Combination procedures may be reported as a single case in the WTIS.
4. The WTIS only captures procedures that take place in a fully-equipped OR, with the exception of cataract procedures.

This model aligns with the main purpose of the WTIS, which is to measure and report on the amount of time a patient is waiting for access to an OR for a surgical procedure to be performed.

For volume-based-funding reconciliation, the ministry uses data submitted to CIHI via DAD/NACRS. If hospitals have any questions about funding definitions or how funded volumes are calculated they should contact their LHIN.

Paediatric Surgery Funding

- Hospitals funded for paediatric procedures must report wait times for all paediatric surgical specialties performed in a fully-equipped OR
- Hospitals funded for adult surgical cases must report wait times for all adult and paediatric surgical specialties performed in a fully-equipped OR